

Dr Turner and Partners

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Turner and Partners on 13 April 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded and all staff had access to the template for recording incidents.
- Staffing levels were monitored to ensure they matched patients' needs. In response to a shortage of GPs and lower than average scores in the national patient survey around availability of appointments the practice had put systems in place. Efforts were being made to employ another GP and more nursing staff and to change the way nurses worked to address the problem.
- Safe arrangements were in place for staff recruitment that protected patients from risks of harm.
- Patients were protected by a comprehensive safety system. There was focus on openness, transparency and learning when things went wrong. Arrangements were in place to ensure that the premises and equipment were hygienically maintained.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Risk assessments were included for those patients who had care plans in place. Staff had received training appropriate to their roles and any further training had been identified, planned and implemented.
- Patients told us they were treated with compassion, dignity and respect and they were involved in decisions about their treatment. Observations during our inspection showed that staff were courteous and helpful towards patients.
- Information about how to make a complaint was readily available and easy to understand. Staff demonstrated that complaints received were dealt with appropriately.
- The practice had purpose built premises and facilities and was well equipped to assess and treat patients.

Summary of findings

- There was a clear leadership structure and staff told us they felt well supported by senior staff. Management proactively sought feedback from patients which it acted on.

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?

The practice is rated as good for providing safe services.

Good



- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to all relevant staff to support improvement.
- Information about safety was recorded, monitored appropriately, reviewed and addressed. Safety issues and significant events were routinely discussed during weekly meetings.
- Risks to patients were assessed and well managed and these were re-visited regularly or when circumstances changed.
- There was a recruitment policy and procedure in place to ensure patients safety was protected. We found that senior staff had adhered to the policy and procedure.
- Staffing levels were regularly monitored to ensure there were enough staff to keep people safe and arrangements were in place to improve the numbers of clinical staff.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and local guidelines were used routinely in the assessment and treatment of patients.
- Staff had reviewed the needs of the local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to the services provided for patients.
- Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.
- Staff had received training appropriate to their role and potential enhanced skills had been recognised and planned for and training put in place.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to provide up to date, appropriate and seamless care for patients. Processes were in place to reduce the risk of unplanned hospital admissions.
- There was a lower than average patient attendance for reviews of diabetes. Practice staff had liaised with the Clinical Commission Group (CCG) about this and employed a nurse

Summary of findings

prescriber. Those patients with complex needs were seen by a visiting diabetic nurse specialist who worked alongside practice nurses. The more recent unpublished data indicated that some improvements had been achieved.

Are services caring?

The practice is rated as good for providing caring services.

- Staff ensured that patients' dignity and privacy were protected and patients we spoke with confirmed this.
- Patients had their needs explained to them and they told us they were involved with decisions about their treatment.
- We saw that staff treated patients with kindness and respect and maintained confidentiality.
- Information for patients about the services available to them was easy to understand and accessible.
- We observed a patient-centred culture and feedback from patients about their care and treatment was positive. Patients told us they were satisfied with the standards of care they received.
- Data published in January 2016 from the national patient survey gave below average results for caring. All patients we spoke with on the day were complimentary about their care. The practice manager told us the demographics of the registered patients may have affected the results.
- Carers were encouraged to identify themselves. Clinical staff provided them with guidance, signposted them to a range of support groups and ensured their health needs were met. The community champion system also provided assistance in this area. Staff who had been trained circulated with patients during busy periods and offered non-clinical advice and support.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Most patients told us it was easy to make an appointment and urgent appointments were available the same day. Some patients told us they sometimes had difficulties in getting appointments when they felt they needed them. Regular patient surveys were carried out to review and improve the appointments system.
- There was a shortage of GPs. Senior staff were seeking to recruit a GP and more nursing staff and to change the way nurses worked to compensate.

Good



Summary of findings

- The practice provided enhanced services. For example, avoiding unplanned admissions by carrying out health reviews and development of individual care plans. Patients were reviewed within three working days of their hospital discharge.
- Information about how to complain was available and easy to understand. Leaflets were available for patients to take away to record their complaint details.
- Evidence showed that senior staff responded quickly and appropriately when issues were raised. Where necessary apologies were provided and improvements made.
- Learning from complaints was shared with all staff and other stakeholders to prevent recurrences.

Are services well-led?

The practice is rated as good for providing well-led services.

- Staff were clear about the vision and their responsibilities in relation to this.
- Staff had identified any shortfalls and had put systems in place to address them.
- There was a distinct leadership structure and staff were well supported by management.
- There were policies and procedures to govern activity and these were accessible to all staff.
- Senior staff actively sought patient feedback about the services they received and where possible made changes to improve them.
- The Patient Participation Group (PPG) were active. A PPG is a group of patients who represent the views of patients and work with practice staff to improve services and the quality of care. Suggestions for improvements had been actioned by senior staff.
- There was a strong focus on continuous learning and improvement at all levels.

Good



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

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

Good



- Practice staff offered proactive, personalised care to meet the needs of older patients.
- Staff kept up to date registers of patients' health conditions and information was held to alert staff if a patient had complex needs.
- Home visits were offered to those who were unable to access the practice and these were commenced each morning due to the duty doctor arrangement that was in place. During recognised busy times a second GP carried out home visits. Patients who had enhanced needs had prompt access to appointments.
- Practice staff worked with other agencies and health providers to provide patient support. The Proactive Care Team (PACT) assessed frail patients in their own home and those in care homes to ensure their health needs were met.
- A GP made regular visits to a care home to visit where practice patients resided to monitor their health needs. They also responded to requests to make extra visits to the home.

People with long term conditions

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

Good



- Nursing staff had lead roles in chronic disease management. A diabetes nurse specialist held some clinics at the practice for the management of patients with complex needs.
- Longer appointments and home visits were available when needed.
- Patients with long-term conditions had structured annual reviews to check that their health and medicine needs were being met. Where necessary reviews were carried out more often.
- The PACT staff assessed and put care plans in place for all unplanned admissions with three days of their discharge from hospital.
- Some patients in this population group had a personalised care plan in place and they were regularly reviewed.
- Clinical staff worked with health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

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

Good



- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. There was a higher than average number of younger patients registered at the practice and on the at risk register.
- Alerts were put onto the electronic record when safeguarding concerns were raised.
- There was regular liaison with the health visitor to review those children who were considered to be at risk of harm.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Children under the age of 10 years were always seen on the day that the appointment was requested.
- Extended hours were in place that allowed children to be seen outside of school hours. Appointments were available from 6.30pm until 7.30pm most Mondays and from 8am until 12pm one Saturday in each month.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.

Working age people (including those recently retired and students)

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

Good



- The practice had adjusted its services to accommodate the needs of this population group to ensure the service was accessible, flexible and offered continuity of care.
- Extended hours were available and telephone consultations with GPs for those patients who found it difficult to attend the practice or if they were unsure whether they needed a face to face appointment.
- Online services were available for booking appointments and ordering repeat prescriptions.
- The practice website gave advice to patients about how to treat minor ailments, health promotion and screening that reflects the needs of this group.

People whose circumstances may make them vulnerable

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

Good



- The practice held a register of patients living in vulnerable circumstances including those who had a learning disability.

Summary of findings

- Practice staff regularly worked with multi-disciplinary teams in the case management of vulnerable patients.
- These patients were told how to access various support groups and voluntary organisations. The community champions' pilot supported this process.
- Staff knew how to recognise signs of abuse, the actions they should take and their responsibilities regarding information sharing.
- There was a clinical lead for dealing with vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

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

- Practice staff regularly worked with multi-disciplinary teams in the case management of patients who experience poor mental health, including those with dementia.
- GPs carried out assessments of patients who experienced memory loss in order to capture early diagnosis of dementia. One GP had a diploma in geriatrics (care of older patients) and was the lead for dementia and frailty care.
- This enabled staff to put a care package in place that provided health and social care support systems in place to promote patients well-being.
- Referrals to other health professionals were made when necessary.
- All patients who had a learning disability had received their annual review.
- Data published in January 2016 informed that only 41% of patients who experienced poor mental health had been reviewed. Staff informed us that due to the dynamics of these patients it was difficult to engage with them. Staff encouraged them to attend the practice for their reviews and had liaised with the CCG about this problem.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016 showed the practice was performing below the local and national averages. There were 119 responses, this equated to a 38% response rate.

- 85% of patients found the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 83% of patients said last time they spoke with a GP they were good at giving them enough time compared with a CCG average of 90% and a national average of 87%.
- 55% of patients found it easy to get through to this surgery by phone compared with a CCG average of 76% and a national average of 73%.
- 90% of patients said the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 76% of patients usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 63% and a national average of 65%.
- 68% of patients felt they did not normally have to wait too long to be seen compared with a CCG average of 60% and a national average of 58%.

In response to the above data a new telephone system was installed November 2015 and an in-house patient survey dated February 2016 resulted in changes to the appointments system and a plan to re-audit in six months.

During our inspection we spoke with seven patients. They told us they were satisfied with the care and treatment they received. Some described their care as excellent. One patient told us they sometimes waited to get an appointment. We also spoke with two members Patient Participation Group (PPG) who were also registered patients. A PPG are a group of patients registered with a practice who work with the practice to improve services and the quality of care. They said they were satisfied with the standards of care they received. As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 19 comment cards and with the exception of one all were positive about the standards of care provided. One patient provided negative comments about numerous aspects of the service but had not submitted a formal complaint. Two commented that it was sometimes difficult to get an appointment when they wanted one.

Dr Turner and Partners

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 and a practice manager, specialist advisors.

Background to Dr Turner and Partners

Dr Turner and Partners provides care for approximately 12,350 patients. The service covers an area of South Worcestershire. The practice holds a General Medical Services contract and provides GP services commissioned by NHS England.

The practice is managed by five GP partners (three male, two female) who between them provide 39 clinical sessions per week. There are two salaried GPs who provide an additional 12 clinical sessions per week. Senior staff are actively seeking to employ a further salaried GP with a view to increasing the partnership to six. GPs are supported by two nurse prescribers, two practice nurses and three health care assistants (HCA). They provide cervical screening, vaccinations, reviews of long term conditions and phlebotomy (taking blood samples) services. Senior staff are in the process of recruiting another nurse prescriber. The practice employs a practice manager, eight administration staff and nine receptionists, one of which is the reception manager and one the reception supervisor.

The practice offers a range of clinics for chronic disease management, anti-coagulant treatment and minor surgery.

Nurse led weekly clinics include diabetes, chronic obstruction pulmonary disease (COPD) and asthma. Other services such as; contraception and vaccinations are provided when required.

The practice is open from 8am until 6.30pm every weekday with the exception of most Mondays when the practice closes at 7.30pm.

Appointments are available from 8.30am until 10am, 10.30am until 12pm and from 2.30pm until 5.30 pm each weekday. Extended hours are provided for pre-booked appointments from 6.30pm until 7.30pm most Mondays and from 8am until 12pm one Saturday of each month. One of the nurse prescribers sometimes sees patients until 7.30pm on Mondays. The duty doctor is available from 8.30am until 6.30pm every day who carries out home visits and sees patients who are unable to obtain an appointment but need to be seen the same day. From April to the end of September each year there is a second duty doctor available from 4pm to assist with those patients who are prepared to sit and wait to be seen. From October to the end of March a third duty doctor is assigned to work from 4pm each day to cope with urgent appointment requests.

The practice has opted out of providing GP services to patients out of hours such as nights and weekends. During these times GP services are provided currently by a service commissioned by NHS South Worcestershire Clinical Commissioning Group (CCG). When the practice is closed, there is a recorded message giving out of hours' details. The practice website and leaflet also includes this information and there are leaflets in the waiting area for patients to take away with them.

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

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

Before inspecting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 13 April 2016. During our inspection we spoke with a range of staff including three GP partners, one salaried GP, one nurse prescriber, one practice nurse and one health care assistant. We spoke with a nurse practitioner and a nurse from the Proactive Care Team (PACT) about how they assessed patients and shared information with clinical staff. We also spoke with the practice manager, the reception supervisor and three receptionists. The co-ordinator for the community champion service described the initiative to us. We spoke with seven patients and two Patient Participation Group (PPG) members who were also registered patients at the practice. PPG's work with practice staff in an effective way that may lead to improved services. We observed how patients were being cared for and talked with family members and reviewed relevant documentation. We reviewed 19 comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record and learning

The practice demonstrated an effective system for reporting and recording significant events and we saw examples which had been reported, recorded and shared with staff.

- Staff told us they would inform the practice manager of any incidents and there was a template available on the practice's computer system for staff to make recordings and send on to the practice manager.
- The practice carried out thorough analysis of the significant events.
- Significant events were a standing agenda item for weekly practice meetings to share lessons learnt and to identify where further improvements could be made.
- When there were unintended or unexpected safety incidents, patients received reasonable support, clear information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Safety was monitored using information from a range of sources, including the Medical and Healthcare products Regulatory Agency (MHRA) alerts and the National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave an accurate overview of safety.
- Patient safety alerts were sent by the practice manager to all relevant staff and if necessary actions were taken in accordance with the alerts such as; individual reviews of patients who may have been prescribed a particular medicine. We saw that prescribing changes had been made where necessary to protect patients from inappropriate treatment. Where action was required as a result of patient safety alerts progress against these were monitored through practice meetings.

We reviewed safety records, incident reports patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, an in-house urine test result had not been entered into the patient's records. A meeting was held with reception and

nursing staff and a new flow chart was developed. The chart was agreed by GPs at the governance and business meeting. Copies of the flow chart were distributed to the reception and nursing teams to prevent a recurrence.

Overview of safety systems and processes

We saw that the practice operated a range of risk management systems for safeguarding, health and safety and medicines management. We saw that risks were addressed when identified and actions put in place to minimise them.

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The policies were appropriate and accessible to all staff. They included contact details of external professionals who were responsible for investigating allegations. There was a lead member of staff for safeguarding who had received appropriate training. GPs attended safeguarding meetings when possible and when requested, provided reports for other agencies. Clinical staff kept a register of all patients that they considered to be at risk and regularly reviewed it. All staff had received training that was appropriate to their role. Staff demonstrated they understood their responsibilities. Staff told us that if necessary they would take the initiative by contacting relevant agencies. One staff member gave us an example of the action they had taken when they had a concern about a patient's safety.
- A notice was displayed in the waiting room and in consulting rooms, advising patients of their right to have a chaperone. All staff who acted as chaperones had been trained for the role. Clinical staff had undergone an enhanced disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Designated non-clinical staff who carried out chaperone duties had undergone a non-enhanced DBS check. The practice manager completed individual risk assessments to justify why these staff did not need an enhanced DBS check. The chaperone policy was reviewed to clearly describe the boundaries when non-clinical staff carried out chaperone duties. Some patients we spoke with were aware that they could request a chaperone and they confirmed that clinical staff offered them this facility.

Are services safe?

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. A practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. They had completed the annual infection control audit on 27 April 2015. We saw that the practice nurse had used the local hospital template for the audit. The results were positive and the actions that were needed were shared with the practice manager and during clinical meetings. We saw that all required actions had been addressed. The practice nurse had carried out individual hand washing audits during October 2015 to check staff hygiene practices. There was an infection control protocol in place and staff had received up to date training.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Practice staff had access to written policies and procedures in respect of a safe management of medicines and prescribing practices.
- The practice had recently employed a pharmacist who had converted to working full time two weeks prior to our inspection. We were told that this was a developing role. The pharmacist was checking the prescribed medicines for all patients discharged from hospital. Checks were carried out regarding medicine reviews and contraceptive and antidepressant medicines. They also ensured that actions had been carried out regarding patient alerts for prescribed medicines.
- We reviewed a range of personnel files of the latest recruits and found
- There were systems in place to ensure test results were received for all samples sent for analysis and the practice followed up patients who were referred as a result of abnormal results.
- There were procedures in place for the monitoring and management of risks to patient and staff safety. A health and safety policy was available to all staff. There were up to date fire safety risk assessments, staff carried out regular fire drills and weekly fire alarm testing.
- 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, clinical waste and legionella testing. (Legionella is a term used for a particular bacteria which can contaminate water systems in buildings.)
- Staff told us the practice was well equipped to assess patients and provide treatment. We saw records that confirmed equipment was tested and regularly maintained. Medical equipment had been calibrated in accordance with the supplier's instructions.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. All grades of staff worked extra shifts and changed their working hours to cover for each other during periods of annual leave. Where GPs were unable to provide full cover for each other they used locum GPs.

Arrangements to deal with emergencies and major incidents

- All staff received annual basic life support training and we saw evidence of this. There were emergency medicines available in the treatment room including those required to treat patients if they had adverse effects when they received minor surgery.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. This included the medicines kept in the GP home visits bag.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Copies of this were held off site by all GP partners and senior staff to eventualities such as loss of computer and essential utilities.

Monitoring risks to patients

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Practice staff carried out assessments and treatment in line with NICE best practice guidelines and had systems in place to ensure all clinical staff were up to date.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to NICE and local guidelines and used this information to deliver care and treatment that met patients' needs.
- Clinical staff monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. The care plan templates included a section for assessing risks to patients.
- Nine palliative (end of life care) and safeguarding meetings were held each year to keep all relevant clinical staff up to date about patients' care needs. District nurses, Macmillan nurses and health visitors attended the meetings.
- The practice took part in the avoiding unplanned admissions scheme. Clinicians reviewed their individual patients and discussed patient needs during meetings to ensure care plans were in place and regularly reviewed. Meetings were held every two months to check that these patients' needs were being met.
- Multi-disciplinary meetings included attendance by a member of the Practitioners Care Team (PACT). PACT staff were employed by the Clinical Commissioning Group whose objective was to make improvements through general practices. The PACT staff consisted of nurse practitioners and nurses who carried out detailed assessments and care planning of those patients who were most at risk in their own homes or those residing in care homes. These included unplanned admissions and frail patients. Records made were fed directly into the patient's records at the practice. PACT staff were based at and liaised directly with GPs at the practice.
- Senior staff were engaging with the Clinical Commissioning Group (CCG) and staff were actively striving to make on-going improvements. CCG's 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. Meetings were held every six months with the CCG to review performance and agree ways of making further improvements to patient care.

- A GP made visits every two to three weeks to a care home where a number of registered patients resided. We contacted the manager of the care home who told us that the visits were helpful for continuing care. They told us that when staff requested a GP attendance that clinicians always responded promptly.
- Weekly sessions were held at the practice by the Gateway mental health team who provided advice, support and signposting for patients who were experiencing poor mental health.
- The practice was piloting the 'time to talk' (community champions) initiative for local residents. We spoke with the co-ordinator who shared their time with two other practices. Two receptionists had been trained to offer the service. They and the co-ordinator circulated with patients at the practice during busy periods. Their role was to engage, listen and signpost patients to non-medical services such as; carers support, bereavement services, Citizens Advice, Age UK and social workers. Each patient was telephoned after two weeks to illicit if improvements had been achieved. Data was sent to the CCG who analysed the results and informed the practice of the outcome. The co-ordinator told us that positive results had been achieved and provided us with an example.

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). Comparisons were also made with the local Clinical Commissioning Group (CCG). QOF data published in January 2016 showed practice was performing in line with CCG and national averages and below in respect of two long-term disorders;

- The atrial fibrillation (irregular heart beat) review rate was 100% which was the same the CCG and 2% above the national average. The practice exception reporting rate was 7%.

Are services effective?

(for example, treatment is effective)

- Performance for asthma related indicators was 97% which was 2% below the CCG average and 1% below the national average.
- Performance for patients with a learning disability was 100% which was the same as the CCG and national averages. There was no practice exception reporting rate.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators were 97% which was 1% above the CCG average and 1% above the national average.
- The percentage of patients with hypertension having regular blood pressure checks was 98% which was 1% below the CCG average and 1% above the national average.
- Performance for diabetes related indicators was 81% which was 13% below the CCG average and 8% below the national average.
- The mental health review rate of 41% was 54% below the CCG average and 52% below the national average.

The practice had an overall exception reporting of 10%, which was 2% greater than the local Clinical Commissioning Group (CCG) average and 1% greater than the national average. Exception reporting is the exclusion of patients from the list who meet specific criteria. This includes, for example, patients who choose not to engage in screening processes, attend reviews or accept prescribed medicines. The practice manager informed us of the difficulties they encountered in patient attendance for their reviews.

We asked GPs, nurses and the practice manager why the data for diabetes and mental health were below average. A GP told us it was difficult to engage with these patients and they relied upon opportunistic occasions to carry out reviews. Nurses told us they contacted patients by phone but they experienced difficulty in encouraging patients to attend the practice. The practice manager advised us that the lack of attendance was due to the demographics of the area they served. Patients received three telephone calls and letters requesting their attendance. QOF data for 2015-16 indicated that there had been a significant improvement in reviews for patients who experienced poor mental health but the practice had not met the target. This data had not been published yet.

The practice held a diabetes management meeting with the CCG and the arrangements put in place for improvements. The practice had held three clinical sessions the previous year with a diabetic nurse specialist in attendance. They worked with the nursing staff by seeing patients who were complex cases. This assisted the practice nurses in developing more knowledge and skills in this area of care. We spoke with a nurse prescriber who told us they planned to hold more diabetic nurse specialist clinics. Improvements had also been achieved with the appointment of a second nurse prescriber in October 2015. Data indicated an increase of reviews by 4.4% for 2015-16; this figure had not yet been validated by the CCG.

Patients who were prescribed specific medicines had received regular reviews to check that their medicines continued to be appropriate for their health needs. Patients who were prescribed treatment for a particular condition were given a booklet that gave a full description of the medicine, contact numbers of external professionals and space for recording blood tests and medicine dosage. A practice nurse held weekly INR (anti-coagulant) clinics for regular re-assessment and treatment reviews of these patients who were also given booklets.

A range of clinical audits had been carried out that demonstrated relevant changes had been made that led to improved patient care. They included:

- An audit regarding irritable bowel syndrome. It identified areas where improvements had been made. The GP who had carried out the audit told us they planned to repeat the audit to check that the improvements made had been sustained.
- Another audit concerned a specific antibiotic and we saw that this was an on-going audit.
- The results of minor surgical procedures had been monitored for complications such as infections that may have occurred. To date there had been none.

Effective staffing

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

- The practice had an induction programme for newly appointed staff that was role specific. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. A staff

Are services effective?

(for example, treatment is effective)

handbook was made available within the practice that provided them with practice information and policies that they could refer to and it was regularly updated by the practice manager.

- The practice had a training programme in place and extra courses were provided that was relevant to roles. For example, administration of vaccines, the cervical screening procedure and reviews of long-term conditions. Staff who administered vaccines could demonstrate how they stayed up to date with changes of the immunisation programmes.
- The learning needs of staff were identified through a system of 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 on-going support during sessions, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. They told us they could ask for additional support at any time. All staff had received an appraisal within the last 12 months.
- 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. Staff we spoke with told us they had the opportunity to build on their knowledge and development to enhance services provided to patients. For example, a health care assistant (HCA) had requested further training to enhance their skills. They were undergoing a two year foundation course at university. When successfully completed they would be able to carry out reviews of patients who had non-complex long-term conditions.
- GPs provided presentations about particular conditions to clinical staff to refresh their knowledge. For example anti-coagulation and atrial fibrillation (irregular heart beat).

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. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services and the out of hours care team.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs in an appropriate and timely way. Care plans were in place for patients who had complex needs and these were regularly updated. The assessments and care planning included when patients moved between services, when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place regularly.

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. GPs we spoke with understood the Gillick competency test. It was used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions. We spoke with two younger patients who told us that GPs treated them as individuals.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records and audits to ensure the practice met its responsibilities with legislation and national guidelines.
- Written consent was obtained and possible complications described before each minor surgery procedure commenced.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

Are services effective?

(for example, treatment is effective)

- These included patients who received palliative (end of life) care, carers of patients, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. All eligible patients who attended the practice had received advice on obesity. Patients were then signposted to relevant services.
- Patients who had complex needs or had been identified as requiring extra time were given longer appointments to ensure they were fully assessed and received appropriate treatment.
- The practice's uptake for the cervical screening programme was 92%, which was 7% below the CCG and 6% below national averages. The practice manager told us that the CCG had carried out a survey regarding the low attendances. The practice had employed a second practice nurse and the attendances had improved. The data for 2015-16 had reached the 100% QOF target. This figure had not yet been validated by the CCG.
- A monthly computer search was carried out to identify patients who required tests and reviews of their long-term conditions. Patients who had not attended were contacted by receptionists and nurses and asked to make an appointment. Letters for patients who had a learning disability were in easy read format to assist them in understanding the need for their health check. Patients who failed to attend for their appointments were contacted by telephone and sent reminder letters advising them of the need to attend.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.
- Newly registered patients received health checks and their social and work backgrounds were explored to ensure holistic care could be provided. If they were receiving prescribed medicines from elsewhere these were also reviewed to check they were still needed.
- Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 80% to 97% and five year olds from 90% to 98%.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and the 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.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consulting and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff told us they responded when patients wanted to discuss sensitive issues or appeared distressed by offering them a private room to discuss their needs.
- The seven patients we spoke with and the two PPG members were complimentary about the way in which all staff communicated with them.
- Of the 19 patient comment cards we received 18 were positive about the service they received and about how staff liaised and kept patients informed. One comment card informed that reception staff were rude and not helpful.
- Throughout our inspection we observed how staff responded to patients and saw they were treated with respect at all times. We saw that staff were friendly and helpful. Patients told us that staff provided either a good or very good service.

Results from the national GP patient survey published in January 2016 showed how patients felt they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%

- 80% of patients said the last GP they saw or spoke with was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 86% of patients said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 92% of patients said they had confidence and trust in the last nurse they saw or spoke with compared to the CCG average of 98% and national average of 97%.
- 86% of patients said the last nurse they spoke with or saw was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.

During our inspection we did not observe or receive negative comments from patients we spoke with about how staff communicated with them. We spoke with the practice manager about the results. They told us they may have been influenced by the demographics of the population the practice served.

Care planning and involvement in decisions about care and treatment

We spoke with seven patients and reviewed 19 comment cards on the day of our inspection which confirmed that patients felt involved with decisions about their healthcare and treatment. Patients spoke positively about the way that GPs and nurses explained their condition and the options available to them about their care needs. However, one comment card provided negative comments about the standards of obtaining prescriptions and other services.

Results from the national GP patient survey published January in 2016 showed how patients responded to questions about their involvement in planning and making decisions about their care and treatment. Results were below local and national averages. For example:

- 82% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 82%.

Are services caring?

- 83% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.
- 81% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 85%.

Clinical staff told us they were aware of the results from the patient survey and were considering ways of improving how they communicate with patients about their health.

We saw a range of health promotion advice and advice leaflets about long term conditions in the waiting area that provided patients with information and support services they could contact.

Staff told us that translation services were available for patients who did not have English as a first language. The service could be arranged for face to face or via telephone. Two staff spoke a total of three languages that were used to assist patients' understanding of their health needs.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations including a bereavement service. Following a bereavement a GP made telephone contact and offered relatives support and if necessary referral to a counselling service. GPs also informed the 'time to talk' staff of the bereavement who signposted relatives to bereavement groups.

The practice's computer system alerted GPs if a patient was also a carer. There were 163 carers on the register which equated to 1.4% of registered patients. There was a dedicated notice board and forms available for patients to complete if they considered themselves to be a carer. The information displayed included details of various support groups. The Worcestershire Carers Association went out to patients own homes and put a care plan in place that included arrangements that allowed carers to attend their own appointments. The 'time to talk' staff signposted carers to various support groups. Carers were offered an annual flu vaccine for their health promotion.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that practice staff were responsive to patient's needs and had systems in place to maintain the level of service provided. The demands of the practice population were understood and arrangements were in place to address the identified needs of patients. Many services were provided from the practice such as; diabetic clinics, other long-term conditions and smoking cessation advice. Services were planned and delivered that took into account the differing needs of patient groups. For example:

- All patients who requested an urgent appointment were seen the same day. Staff experience indicated that some patients routinely requested on the day appointments. The additional duty doctor arrangements ensured that patients' demands were met.
- Telephone consultations were available to assist those patients who experienced difficulty in attending the practice or if they were unsure if they needed a face to face consultation.
- Patient surveys were carried out at least every six months to gain opinions about the appointments system and changes made to reflect the results. For example, as a result of the latest patient survey in February 2016, 12% of appointments were made available on line.
- Home visits were available for elderly patients and those who were unable to access the practice.
- Urgent access appointments were available for children and those with serious or complex medical conditions. These patients were seen on the day even if the clinical sessions were fully booked.
- There were longer appointments available for people with a learning disability and patients with other long term conditions.
- There were extended hours available to improve patient access.
- Easy read letters and leaflets including how to make a complaint were available for patients who had a learning disability to enable their understanding.

- There were facilities for patients with a disability, a hearing loop and translation services available.

Access to the service

The practice was open from 8am until 6.30pm every weekday with the exception of most Mondays when the practice closed at 7.30pm.

Appointments were available from:

- 8.30am until 10am, 10.30am until 12pm and from 2.30pm until 5.30 pm each weekday.
- The duty doctor was available from 8.30am until 6.30pm every day who carried out home visits and saw patients who were unable to obtain an appointment but needed to be seen the same day. From April to the end of September each year there was a second duty doctor available from 4pm to assist with those patients who were prepared to sit and wait to be seen. From October to the end of March a third duty doctor was assigned to work from 4pm each day to cope with urgent appointment requests.
- Extended hours were provided for pre-booked appointments and telephone consultations from 6.30pm until 7.30pm most Mondays. Two GPs were available on these occasions and sometimes a nurse prescriber. Appointments were also available one Saturday per month from 8am until 12pm when three GPs were available.

Senior staff informed us that there were no patients with temporary registration but some patients who did not have a home address were registered with the practice.

Results from the national GP patient survey published January 2016 showed that patients' satisfaction with how they could access care and treatment were below local and national averages and patients we spoke with on the day were able to get appointments when they needed them. For example:

- 55% of patients said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.
- 40% of patients said they were able to get an appointment to see or speak with someone last time they tried compared to the CCG average of 61% and the national average of 59%.

Are services responsive to people's needs?

(for example, to feedback?)

- 71% of patients described their experience of making an appointment as positive compared to the CCG average of 78% and national average of 73%.

However, the patients we spoke with on the day of our inspection were satisfied with access to the service. One patient we spoke with told us they had recently been contacted at home and requested to attend the practice after closing time to commence treatment. They said that a GP and a receptionist had continued working until they had been seen. Three of the 19 comment cards told us it was sometimes difficult to get an appointment when they needed one.

To improve the telephone access the practice had installed a new telephone system in November 2015 which had 12 incoming lines.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with

recognised guidance and contractual obligations for GPs in England. Information about how to make a complaint was available on the practice's website, in the practice leaflet and in the waiting area.

- The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.
- The practice kept a complaints log and there had been 22 formal complaints received since January 2015.
- We saw that complaints had been dealt with in an effective and timely way. Complaints were discussed with staff to enable them to reflect upon them and any actions taken to reduce the likelihood of future incidents. Complaints were reviewed regularly during staff meetings to ensure that appropriate actions had been taken.
- The practice manager told us they dealt with verbal complaints promptly through discussions with patients.

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

Senior staff had a vision to deliver quality care and promote positive outcomes for patients. There was a statement of purpose with clear aims and objectives which staff understood.

- Clinical staff met regularly with other practices within Worcestershire to share achievements and to make on-going improvements where possible.
- Senior staff had identified that further clinical staff were needed and were trying to recruit another GP and a practice nurse in advance of one who was planning to leave the practice.
- To assist in alleviating the GP shortage a nurse prescriber was due to commence reviews of long-term conditions of patients in their own homes.
- Systems were in place for the recruitment of another nurse prescriber.
- Further staff development was encouraged. For example, a health care assistant (HCA) was undertaking a foundation degree course to enable them to carry out reviews of non-complex patients.
- Ways of developing the pharmacist role were being considered to relieve pressures on GPs.
- The practice had a five year business plan and meetings were held quarterly to discuss progress against it.

Governance arrangements

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

- There was a defined staffing structure and staff were aware of their own roles and responsibilities.
- Staff worked as a team and supported each other in achieving good patient care.
- Clear methods of communication that involved the whole staff team and other healthcare professionals ensured dissemination of best practice guidelines and other information.

- Staff attended regular team meetings to discuss issues, cascade information, patient care needs and further develop the practice.
- Practice specific policies were implemented and were available to all staff including a whistle blowing policy.
- Clinical staff had an understanding of the performance of the practice and an action plan had been implemented to improve performance. This included the results of the national patient survey that was published in January 2016.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice effectively and promote high quality care. All staff we spoke with during the inspection demonstrated that they made positive contributions towards a well-run practice. They prioritised safety, on-going service improvements and compassionate care. The partners were visible in the practice and staff told us they were approachable at all times.

Staff said they felt respected, valued and supported, particularly by the partners in the practice. Staff we spoke with told us they were encouraged to consider their training needs with a view to enhancing their roles.

The practice had systems in place for knowing about notifiable safety incidents. When there were unexpected or unintended safety incidents practice staff gave affected people reasonable support, information and if necessary, written apology.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. It had gathered feedback from patients through the Patient Participation Group (PPG) and through surveys and complaints received. A PPG are a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG met regularly and they regularly liaised with senior staff between these times. PPG members said they felt that staff

Are services well-led?

Good 

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

listened to them and that changes would be made whenever practicable. For example, the PPG had suggested and were consulted about the new telephone system that was installed in November 2015. Another improvement was made when the PPG reported a long waiting time when patients had appointments with nursing staff. Three PPG members had helped in directing patients during the flu vaccination clinics.

Information was gathered from patients and staff through meetings and appraisals about issues, concerns or where improvements could be made. Staff and the PPG members were asked to comment before the changes were implemented.

The practice participated in the 'Friends and Family Test' and the results were sent to the CCG each month. From April 2015 until March 2016 the overall results were that 74% of patients would recommend the practice to others and 12% were neither likely nor unlikely to recommend the practice to other people.

Continuous improvement

There was focus on continuous learning and improvement at all levels within the practice. Discussions were in progress through six monthly meetings about how they would implement the proposed South Worcestershire Clinical Commissioning Group (CCG) model of caring strategy.