Severn Valley Medical Practice

Quality Report

1 Ingles Drive
St Johns
Worcester
WR2 5HL
Tel: 01905 422883
Website: www.severnvalleymedicalpractice.co.uk

Date of inspection visit: 15 April 2015
Date of publication: 03/09/2015

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

Summary of this inspection

Page

Overall summary 2
The five questions we ask and what we found 4
The six population groups and what we found 7
What people who use the service say 11
Areas for improvement 11
Outstanding practice 11

Detailed findings from this inspection

Our inspection team 13
Background to Severn Valley Medical Practice 13
Why we carried out this inspection 13
How we carried out this inspection 13
Detailed findings 15

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Severn Valley Medical Practice on 15 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was outstanding for providing services to older people and good for providing services to patients 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 and those experiencing poor mental health or living with dementia.

Our key findings were as follows:

- The practice had systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to their patients.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- The practice was clean and hygienic and had arrangements for reducing the risks from healthcare associated infections.
- Patients' needs were assessed and the practice planned and delivered care following best practice guidance.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had an established a well trained team with expertise and experience in a range of health conditions.
- Patients said their GP listened to them and that they received prompt care and attention. They told us staff were polite, informative and compassionate.
- Information about services and how to complain was available and easy to understand. The practice responded to complaints in a positive way.
- The practice communicated with patients and acted on feedback to improve the service they provided.

We saw several areas of outstanding practice including:

Summary of findings

- The practice employed a prescribing pharmacist for 30 hours a week. This resulted in increased numbers of medicines reviews completed and greater availability of GP appointments. Other improvements included more proactive checks of patients' medicines on discharge from hospital and a faster turnaround for repeat prescriptions.
- The practice proactively followed up and monitored patients with risk factors for osteoporosis, a condition that affects the bones, causing them to become weak and fragile and more likely to break. Individual appointments were arranged throughout the year and the practice also held osteoporosis clinics twice a year. The practice had scored 6.6% above the CCG average and 16.6% above the England average in QOF for prevention of fractures due to patients having fragile bones.
- The practice worked closely with Age UK and with local care homes for older people. They had introduced an assessment template to support care home staff to make timely and appropriate requests for GP visits. The practice had also initiated regular meetings with care home managers to improve communication and multi-disciplinary working. Patients from the care homes had been invited to join the practice's patient participation group (PPG). The practice was working in partnership with Age UK on an over 75s care project aimed at identifying and addressing unmet social need and had a member of the team with responsibility for co-ordinating this. The practice hosted a monthly Age UK clinic at the branch surgery to make it easy to refer patients to see one of their team about non-medical concerns.

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

Importantly the provider should:

- Review and update the complaints procedure including removing references to the primary care trust (PCT) a commissioning organisation which no longer exists.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice investigated significant events thoroughly and had an open approach to learning and improving when anything went wrong. The practice assessed risks to patients and had systems for managing specific risks such as fire safety, infection control and medical emergencies. There were enough staff to keep people safe. Infection control and general cleanliness at the practice were well organised. The practice employed a prescribing pharmacist for 30 hours a week to enhance the safe management of medicines and prescribing.

Are services effective?

Good

The practice is rated as good for effective. Patients received care and treatment which took account of National Institute for Health and Care Excellence (NICE) and local guidelines. The practice was proactive in the care and treatment provided for patients with long term conditions and worked in partnership with other health professionals. National data showed that the practice had not scored as highly as others in respect of monitoring the care and treatment of some patients during 2013/14. The practice provided data to show they had improved during 2014/15. The practice had lower than average accident and emergency admission rates and lower than average unplanned admission rates for patients with certain long term conditions.

Staff received training appropriate to their roles and the practice encouraged their continued learning and development. The practice nursing team included two nurse practitioners with master's degrees and another who was also a nurse prescriber. These nurses were able to see patients with minor illnesses, who would otherwise have needed to see a GP. This increased the overall numbers of appointments available for patients. The practice worked closely with local care homes. They had introduced an assessment template to support care home staff to make timely and appropriate requests for GP visits. They had allocated a nurse practitioner to develop a lead role in providing first line care to patients living in the homes. Care home staff said that this benefitted patients because the nurse was getting to know each person well.

During 2014 the practice appointed a prescribing pharmacist for 30 hours a week. Their role included medicines reviews and the practice told us they completed 17% more medicines reviews in the first three months of 2015 compared with the same period in 2014.

Summary of findings

The pharmacist had done 90% of these which had increased the number of appointments available for patients who needed to see a GP by an average of 80 a week across both sites. The pharmacist also ensured that changes to patients' medicines while in hospital were rapidly and correctly updated in the practice records when they were discharged. Patients received their medicines faster because the turnaround time for repeat prescriptions had reduced from 72 hours to between 24 – 48 hours.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us that staff were always helpful and several mentioned being treated in a kind and caring way. Others described the team as polite, courteous, informative and compassionate. One person highlighted that they appreciated the positive attitude of all members of the practice team. Care home staff told us that the GPs treated patients respectfully and kindly and were good at developing a rapport with patients including those living with dementia. National data showed that the practice scored well for treating patients with care and concern and involving them in decisions about their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and recognised the importance of developing their services to meet current and future demand. The practice had taken steps to improve access to the service in response to patient feedback; this included extended hours before 8am and after 6pm every day and one Saturday morning a month which had provided 525 additional appointments with GPs and practice nurses every quarter. Same day appointments were available and children and patients with an urgent need were given priority. Patients could book appointments with GPs two weeks in advance and practice nurses four weeks in advance.

We found examples of the practice team responding sensitively to the individual needs of patients which enabled them to receive the care and treatment they needed.

There was a clear complaints system and the practice responded to issues raised including arranging face to face discussions with patients who made a complaint. We highlighted to the practice that the complaints procedure still referred to the primary care trust a commissioning organisation which no longer exists.

Summary of findings

The practice provided diagnosis and minor surgical procedures for patients from other practices with skin conditions and were about to extend this to other minor surgical procedures and long acting contraceptive devices and implants.

The practice provided medical care for patients staying at a local hostel and to students from the nearby University of Worcester. They had worked with care home staff to improve communication and provide a more responsive service.

As well as online prescription ordering, a repeat dispensing system was available for patients to reduce how often they needed to request repeat prescriptions.

Because the River Severn in Worcester floods and can cut one half of the city off from the other, the practice took part in reciprocal arrangements to provide home visits for patients whose own practices' GPs could not reach them. They explained that this was usually co-ordinated with the NHS England area team.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a vision and strategy for the future which took the future needs of the population into account. There were a range of meetings for the practice team to learn and share knowledge and information. The practice used information technology to help them communicate effectively. The practice had a number of policies and procedures to govern activity and these were available for all staff to access on the practice computer system.

The practice had a patient participation group (PPG) which had been running by email but was about to begin having face to face meetings. Patients living in local care homes for older people had been invited to be part of the PPG and care home staff told us people were looking forward to being involved in this.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Outstanding ☆

Older people

This practice is rated as outstanding for the care of older people. Patients over the age of 75 had a named GP and GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice offered proactive, personalised care to meet the needs of the older people in its population. Older patients were assessed to ensure they received the care they might need in respect of frailty or dementia. The practice had systems to alert staff to patients with significant health and care needs and those at the end of their life.

The practice provided medical care to patients living in seven local care homes for older people. The GPs and a nurse practitioner routinely visited the homes every week and when requested by care home staff. The practice had initiated regular meetings with senior staff from the care homes to improve communication and partnership working. They had introduced an assessment template to support care home staff to make timely and appropriate requests for GP visits. The practice had invited care home patient representatives to join the patient participation group (PPG). One care home manager told us several people were looking forward to being involved in this. The practice told us three people had confirmed that they would attend the next meeting in September 2015.

The practice was working in partnership with Age UK on an over 75s care project aimed at identifying and addressing unmet social need and had a member of the team with responsibility for co-ordinating this. The practice hosted a monthly Age UK clinic at the branch surgery to make it easy to refer patients to see one of their team about non-medical concerns. Patients had emailed the practice to thank them for putting them in touch with Age UK and gave examples of help they received. This included help with Blue Badges, personal independence payments and referrals to Age UK dementia services.

Two GPs at the practice had a specific interest in osteoporosis, a condition that affects the bones, causing them to become weak and fragile and more likely to break. They proactively followed up and monitored patients with risk factors such as early menopause or fractures to identify and support patients who had this condition and identify those who may be at risk. Individual appointments were arranged throughout the year and the practice also held osteoporosis clinics twice a year. The practice had scored 6.6% above the CCG average and 16.6% above the England average in

Summary of findings

QOF for prevention of fractures due to patients having fragile bones. QOF is a voluntary incentive scheme for GP practices in the UK. The practice was involved in a falls pilot with Warwick University which evaluated the effectiveness of primary care fall prevention interventions. This had looked at the impact of patients receiving advice only, advice with exercise and advice with Age UK support. They were waiting for the findings but hoped to gain evidence regarding the signposting of patients to the correct service for them.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions although it required improvement in respect of providing an effective service to this group. Nursing staff had lead roles in supporting patents with long term conditions and patients at risk of unplanned hospital admission were identified as a priority. National data showed that the practice had not scored as highly as others in respect of monitoring the care and treatment of patients with long term conditions, including diabetes, during 2013/14 but the practice provided data that showed they had improved during 2014/15. The practice had lower than average accident and emergency admission rates and lower than average unplanned admission rates for patients with certain long term conditions. The practice had systems to respond to the needs of patients with significant health problems which could be life threatening or lead to hospital admission and those at the end of life. Longer appointments and home visits were available when needed.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. Immunisation rates were higher than the local CCG average for all except one booster for children at five years. The practice provided family planning advice and women could have long acting contraceptive devices and implants provided at the practice. Midwives and health visitors were based within the same building as the practice so that pregnant women and families with babies and young children could access all their healthcare in one place. The GPs and practice nurses worked with other professionals where this was necessary, particularly in respect of children living in vulnerable circumstances. Appointments were available outside of school hours.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age people, recently retired people and students. The practice had taken steps to improve access to the service in response to patient feedback. This included extended hours before 8am and after 6pm every day

and one Saturday morning a month. This had provided 525 additional appointments with GPs and practice nurses every quarter. The practice had also free up 80 GP appointments week by appointing a prescribing pharmacist whose role included carrying out the majority of medicines reviews. Same day appointments were available and patients with an urgent need were given priority. Patients could also book appointments with GPs two weeks in advance and practice nurses four weeks in advance. Patients could book appointments and order prescriptions online and a repeat dispensing system was available for patients to reduce how often they needed to request repeat prescriptions. Students were offered meningitis C vaccinations and were able to access contraceptive advice at the practice.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a learning disability (LD) register and patients with learning disabilities were invited to attend for an annual health check. The practice registered people staying at a local hostel as temporary patients. They viewed the provision of healthcare to these patients as a high priority due to their potential vulnerability and reception staff were aware to be flexible about arranging their appointments. The practice nurses explained that one challenge was being able to follow up test results and ongoing treatment with these patients but did their best to do so. For example, women were encouraged to find out the results of cervical screening.

The practice provided medical care to patients living in three local care homes for people with learning disabilities. We spoke with staff from two of the homes who confirmed that patients had annual reviews, flu vaccinations and annual health checks. The practice had formats which were suitable for some patients' communication needs although care home staff told us some people's communication needs meant these could not be used. Senior staff from one care home gave us an example of a patient who needed a procedure but were anxious and did not understand it. They told us a GP and a nurse worked in partnership with them for over three months to help the person understand by introducing the necessary equipment to them gradually. As a result the patient was no longer anxious and had this procedure whenever it was necessary.

The staff team were aware of their responsibilities regarding information sharing and dealing with safeguarding concerns.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had identified patients at the practice who were living with dementia or other mental health conditions. The practice team recognised that these patients were often reluctant to engage with health care services and used all opportunities to provide them with the health checks and screening they needed, including home visits when appropriate. The practice worked in partnership with specialist mental health professionals.

We learned about the flexibility shown to a patient with very specific needs which made visiting the practice very challenging for them. In addition to booking longer appointments for this patient the staff went out of their way to help them manage their experience during their visit to the practice.

The practice had reviewed the needs of 11% fewer patients experiencing poor mental health than the national average and had taken steps to develop and improve services for these patients. They had performed better in respect of patients living with dementia where 93.55% of patients had been seen in person for a review of their care and treatment compared with the national average of 83.82%.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 22 Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with three patients.

Data available from the NHS England GP patient survey when we planned our inspection showed that patients had scored the practice slightly higher than average for overall experience and for their nurse involving them in decisions about their care and treatment. Patients had also scored the practice higher than average for the GPs and nurses involving them in decisions about their care.

The information we received from patients reflected the national data and presented a positive picture of patients' experiences at Severn Valley Medical Centre. Patients described being listened to by their GP and receiving prompt care and attention when this was needed including during long periods of being unwell. Some patients commented that staff were always helpful and several mentioned being treated in a kind and caring way. Others described the team as polite, courteous, informative and compassionate. One person highlighted that they appreciated the positive attitude of all members of the practice team and several used the comment cards to express their thanks to the practice for the care and treatment they received.

Staff we spoke with at six care homes for older people and 2 for people with learning disabilities were positive about the service the practice provided to their patients. They told us the GPs provided a caring and responsive service and involved patients in their care as far as this was possible.

Some patients wrote comments about the practice environment which they described as clean, hygienic and safe.

Two patients felt that the appointment system could be more flexible but another said the practice had got the balance between same day urgent appointments and pre-bookable appointments right. One patient wrote that the practice had improved access to appointments and that the system worked for them. They felt that this might not be the case for some working people.

Patients appreciated having computer access for prescriptions and appointments and one described this as excellent. One person felt that prescriptions took too long to be ready and another was unclear about arrangements for emergency appointments at the weekends.

Areas for improvement

Action the service SHOULD take to improve
Importantly the provider should:

- Review and update the complaints procedure including removing references to the primary care trust (PCT) a commissioning organisation which no longer exists.

Outstanding practice

- The practice employed a prescribing pharmacist for 30 hours a week. This resulted in increased numbers of medicines reviews completed and greater availability of GP appointments. Other improvements included more proactive checks of patients' medicines on discharge from hospital and a faster turnaround for repeat prescriptions.
- The practice proactively followed up and monitored patients with risk factors for osteoporosis, a condition that affects the bones, causing them to become weak and fragile and more likely to break. Individual appointments were arranged throughout the year and the practice also held osteoporosis clinics twice a year.

Summary of findings

The practice had scored 6.6% above the CCG average and 16.6% above the England average in QOF for prevention of fractures due to patients having fragile bones.

- The practice worked closely with Age UK and with local care homes for older people. They had introduced an assessment template to support care home staff to make timely and appropriate requests for GP visits. The practice had also initiated regular meetings with care home managers to improve communication and multi-disciplinary working. Patients from the care homes had been invited to join the practice's patient participation group (PPG). The practice was working in partnership with Age UK on an over 75s care project aimed at identifying and addressing unmet social need and had a member of the team with responsibility for co-ordinating this. The practice hosted a monthly Age UK clinic at the branch surgery to make it easy to refer patients to see one of their team about non-medical concerns.

Severn Valley Medical Practice

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 advisor, a practice manager specialist advisor and a second CQC inspector.

Background to Severn Valley Medical Practice

Severn Valley Medical Centre is situated on the southern side of the river Severn in Worcester and has a catchment area with relatively low levels of social and economic deprivation. It has around 20,000 patients. The practice has a branch surgery at Warndon known as Lyppard Grange Medical Centre which is on the northern side of the river. We had no specific information about Lyppard Grange to lead us to visit there and this inspection therefore focussed on the main site. The practice has a free car park with disabled spaces nearest to the entrance.

The practice population is broadly in line with the national average for all age groups other than the 40 to 50 age group which is higher than the national average. The practice provides medical care to people while they are staying at a local hostel and to patients living in seven care homes for older people and three for people with learning disabilities. They also cater for students at Worcester University.

The practice has five partners and 10 salaried GPs. Six of the GPs are male and nine are female providing patients with a choice. The practice has three nurse practitioners and seven practice nurses supported by a team of health care assistants and phlebotomists (staff trained to take blood). The practice also employs a prescribing pharmacist for 30 hours a week.

The clinical team are supported by a practice manager, assistant practice manager, two office managers and an IT manager. This management group leads a team of secretaries, administrative staff senior receptionists and receptionists.

The practice provides a range of minor surgical procedures, including for skin conditions. It had a service level agreement with another practice to provide dermatology services. The practice is planning to extend this to other minor surgical procedures and the provision of long acting contraception.

The practice told us that they had experienced a number of changes in the last two years including the retirement of two senior partners and a long standing practice manager. They had inherited a large number of patients with complex needs when another local practice re-located. These issues had created challenges for the practice in the short term which they believed they were well on the way to overcoming.

Severn Valley Medical Centre is training practice for GP trainees. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. The practice is also a teaching practice and provides placements for medical students who have not

yet qualified as doctors. The practice told us they only allocated two places at any one time to GP trainees and/or medical students so that their needs could be properly accommodated.

The practice had an established patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care. This had been running as a 'virtual' group using email for three years but was due to have its first face to face meeting the week following our inspection.

The practice has a General Medical Services (GMS) contract with NHS England.

The practice does not provide out of hours services to their own patients but provided two telephone numbers for patients to use for the local GP out of hours operated by Care UK, a national company.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme 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 references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Worcestershire Clinical Commissioning Group (CCG), NHS England and Worcestershire Healthwatch. We carried out an announced visit at Severn Valley Medical Centre on 15 April 2015 but did not visit the Lyppard Grange branch surgery at Warnden. Before the inspection we sent CQC comment cards to the practice. We received 22 completed cards which gave us information about those patients' views of the practice.

During the inspection we spoke with 10 staff including the practice manager, GPs, practice nurses and members of the reception and administrative teams. We also spoke with three patients and senior staff from nine care homes.

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 living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included significant events, national patient safety alerts and comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The practice had been recording significant event information for five years showing an established process for monitoring safety.

Learning and improvement from safety incidents

The GPs, practice nurses and practice manager received national patient safety alerts, distributed these to the team and saved them on the practice computer system where all members of the team could access them.

The practice had a protocol and system for reporting, recording and monitoring significant events, incidents and accidents. The system included a suitable reporting form that all staff had access to. Staff knew they were expected to report any significant event to the practice manager or to a GP depending on the issues involved. Staff explained that minor issues and near misses were recorded as significant events as well as more serious concerns. All significant events were acted on immediately if necessary and were discussed at the monthly partners' meetings. The team also met twice a year for a review of significant events and planned to increase this to four times a year. Information about significant events, including minutes of meetings was circulated to staff to help ensure shared learning. Staff confirmed that patients or their families were always told about significant events affecting them and that the practice apologised when mistakes were made. The practice planned to start informing the patient participation group (PPG) about significant events and the outcomes of these. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

Practice nurses gave us an example of changes the practice had made when an incorrect dose of a travel vaccine had been provided by the local pharmacy. No harm had been caused but the practice had informed the patients' parents of the error and improved their checks on medicines before administering them.

Reliable safety systems and processes including safeguarding

The practice had a lead GP for safeguarding vulnerable adults and children. The staff we asked knew who this was and who to tell if they had a safeguarding concern. Staff understood their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect. Members of the team knew how to access information about safeguarding on the practice's computer system.

All the GPs took part in weekly multi-disciplinary team meetings with other relevant professionals involved in safeguarding and alternated the venue between the main practice and the branch surgery. Other professionals at the meetings included local health visitor teams, midwives, community psychiatric nurses and a representative from Worcestershire Carer Support. Staff told us that the practice benefited from having health visitors and school nurses based within the same building which made it easy and convenient to speak with colleagues whenever necessary.

The practice had safeguarding policies and procedures for children, young people and adults. These were based on national guidance and had been tailored to the needs of the practice. Important contact numbers for the multi-disciplinary child and vulnerable adult safeguarding teams were readily available to assist staff. The practice had clear systems, including alerts on the practice computer system which made sure that relevant staff were aware of any child known to be at risk or who was in the care of the local authority.

We saw evidence that staff regularly completed safeguarding training for children and vulnerable adults at a suitable level according to their role. Staff we spoke with confirmed this and some gave us examples of occasions when they had raised concerns using the correct procedures.

A chaperone is a person who acts as a safeguard and witness for a patient and health care professionals during a medical examination or procedure. The practice had a chaperone policy but we noted that it did not provide guidance to staff regarding where they should stand during procedures. However, staff we spoke with understood what they should do. Signs were displayed within the practice to inform patients that chaperones were available. Staff told us that the nurses and health care assistants carried out chaperone duties had completed chaperone training and

all had Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable. Non-clinical staff completed chaperone training so they understood what this involved and could explain it to patients but did not carry out this role. The practice had therefore assessed that they did not need DBS checks. This was not formalised as a written document but the practice addressed this after the inspection.

Medicines management

The practice had employed a prescribing pharmacist for 30 hours a week to contribute to the safe and effective management of medicines at the practice. The pharmacist had developed comprehensive new policies and processes. These included processes to ensure that patients' medicines were reviewed and that changes to patients' medicines while in hospital were rapidly and correctly updated in the practice records when they were discharged. These reviews and checks were mainly done by the pharmacist who was supported by a named GP who monitored and supervised their practice. The practice policy was that all prescriptions completed by the pharmacist were checked and signed by a GP before they were issued to patients.

The practice had a system for sharing information about national medicines safety alerts and new guidance. We saw evidence of this working in practice. An alert about the safety of a medicine was received and staff had checked batch numbers to establish they had not used this medicine in the past and did not have any at the practice.

We looked at the arrangements for the security of blank prescriptions. The practice stored prescription pads securely but was not recording the allocation of these to the GPs. Immediately after the inspection the practice provided evidence that it had introduced a system in accordance with national guidelines for the safe storage, recording and use of prescriptions.

The practice had some controlled drugs (CDs) at the practice. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. The practice had clear procedures describing how these should be managed. The CDs were stored in a suitable controlled drugs cupboard, access to them was restricted and the keys were held securely. The practice had suitable arrangements for the destruction of CDs. We saw that they kept records to monitor stocks of CDs, including for any items that were out of date and had been set aside to be destroyed.

The practice nurses were responsible for maintaining vaccine stocks. We saw that the practice had arrangements for the receipt, storage and recording of all vaccines coming into the practice. The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance and had up to date copies of these to refer to. We saw evidence that staff monitored and recorded the temperatures of the fridges where vaccines and other temperature sensitive medicines were stored.

Cleanliness and infection control

The practice was visibly clean and the practice had policies and procedures to help the practice manage infection prevention and control. Hand washing facilities and hand gel were available for staff and patients.

General cleaning of the premises was carried out by an external cleaning company. There were cleaning schedules in each room to help the company and the practice monitor the standards of cleanliness. Cleaning equipment and products were kept securely and information about safe use of cleaning materials was readily available.

One of the practice nurses was the lead for infection prevention and control (IPC) and had completed relevant training to support them in this role. Staff (including those employed by the external cleaning company) completed regular IPC training arranged by the practice. Clinical staff and the practice manager shared relevant information regularly at clinical and management meetings. Minutes of these discussions and IPC updates were emailed to other staff. We saw evidence of audits of IPC at the practice during the last two years with action plans showing that the practice had made a series of improvements and continued to monitor this.

The practice had a plentiful supply of personal protective equipment, such as disposable gloves and aprons, for staff to use. There were disposable privacy curtains in treatment rooms and these were labelled so staff could monitor when they were changed. Specific equipment and products were available to deal with any bodily fluids that might need to be cleaned and staff knew where these were kept.

Good

Are services safe?

There was a sharps injury policy and procedure so staff had information about the action to take if they accidentally injured themselves with a needle or other sharp medical device. The practice had a process for confirming that staff were protected against Hepatitis B.

Legionella is a bacterium that can contaminate water systems in buildings. The practice had a legionella risk assessment which identified the premises as low risk because it was a modern building with no hot or cold water storage tanks or air conditioning. The practice therefore did not carry out ongoing testing.

The practice had contracts for the collection of non-clinical and clinical waste and suitable locked storage for all waste that was waiting for collection.

Equipment

In our discussions with staff we established that the practice had the equipment they needed for the care and treatment they provided. We saw evidence that equipment was maintained and re-calibrated as required. This work was carried out by a specialist company and was scheduled to be done in July 2015. We saw evidence that portable electrical equipment was tested every year.

Staffing & Recruitment

The practice had an experienced and skilled staff team with clear responsibilities and lines of accountability. The overall staffing levels and skill mix at the practice ensured that they had sufficient staff to maintain a safe level of service to patients. There was a low staff turnover with 24 of the 50 staff employed at the practice for more than 10 years. The practice had two office managers whose role included the staff rotas and monitoring staff availability to ensure that adequate cover was in place.

The practice had a recruitment policy and used a specialist external company to support them with this and other staffing matters including disciplinary issues. We saw that the practice carried out checks through the DBS for the majority of staff working at the practice. The practice did not obtain DBS checks for staff who never had unsupervised contact with patients. The practice was clear about how they reached this decision but did not have a formal written risk assessment. They addressed this after the inspection. We saw that the practice had thorough processes for checking the suitability and appropriate professional registration status of any locum GPs employed to work at the practice.

Monitoring Safety and Responding to Risk

The practice had a health and safety risk assessment which was scheduled to be updated in May 2015.

The practice had arrangements for identifying and prioritising those patients in high risk groups such as older patients, those with long term conditions, mental health needs, dementia or learning disabilities and those at the end of life. The practice computer system was used to inform staff of individual patients who might be particularly vulnerable. The practice also included patients with less common long term conditions who may not be on one of the main patient registers as priority patients. This was to help ensure that they also received the necessary monitoring of their health, particularly when the condition was one which had significant or life limiting implications such as multiple sclerosis.

The practice had a zero tolerance approach to abusive or aggressive behaviour from patients towards other patients or staff. Information about this was included in the patient leaflet and displayed in the practice. Staff described an event when a GP had been assaulted. The practice had liaised with the Clinical Commissioning Group (CCG), the NHS England area team and the local medical committee (LMC) regarding the action to take in respect of the patient involved. The practice had recorded this as a significant event and identified learning points to improve safety.

Arrangements to deal with emergencies and major incidents

Staff at the practice completed annual cardiopulmonary resuscitation (CPR) training. The practice manager had a system for monitoring when refresher training was due. Staff showed us that there was an emergency call system on the practice computer system that staff could activate if there was a medical emergency. This alerted all staff to any emergency in the building including which room this was in. In addition there were alarms in each room which did not rely on the computer system.

The practice had oxygen, an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm) and emergency medicines available for use in a medical emergency. We saw that staff checked these every month to make sure they were available and ready for use when needed.

Good

Are services safe?

The practice had a fire risk assessment and had reviewed this in December 2014. This included information about evacuation arrangements for staff and patients with specific needs. There were designated fire marshals at both sites. The practice had fire safety records confirming that they carried out fire alarm tests and regular checks of fire safety equipment.

The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. The plan was available to all staff. The practice manager had a copy at home and there were copies at both sites so that it was available all of the time.

The practice told us that because the River Severn in Worcester floods and can cut one half of the city off from the other, they took part in reciprocal arrangements to provide home visits for patients whose own practices' GPs could not reach them. They explained that this was usually co-ordinated with the NHS England area team.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had a system for distributing and saving current best practice guidance such as from the National Institute for Health and Care Excellence (NICE) and local sources such as NHS England. The GPs and practices nurses showed us that they had access to these through the practice's computer system.

The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. Data available to us for 2013/14 showed that the practice had achieved lower QOF results than the CCG and national averages in many areas although in others they had higher scores. The practice had achieved 84% of available points compared with the national average of 94%. The practice told us they were aware that they had not previously scored highly in their QOF figures and that this was in part due to significant changes within the practice team and inconsistent coding in patient records. They were confident that this was an area that they had already significantly improved. They provided information about their 2014/15 QOF data which had not been formally published. This showed that they had achieved 97% of the available points.

The GPs used clear clinical templates which were evidence based and provided well organised information to assist them in assessing and recording patients' care and treatment. The practice was planning to introduce tablet computers for GPs and nurse practitioners to use during home visits to provide remote access to clinical records and enable notes to be entered into patients' records immediately. They were also looking into the potential for introducing remote healthcare monitoring systems.

Management, monitoring and improving outcomes for people

The number of older patients registered with the practice was in line with the national average. Patients over the age of 75 had a named GP designated by the practice but could choose to see any of the GPs if they wished.

The practice provided medical care for patients living in seven local care homes for older people and had completed care plans for those patients. We spoke with senior staff at six of the homes who were all positive about the care patients received from the practice. They had introduced an assessment template to support care home staff to make timely and appropriate requests for GP visits. One of the nurse practitioner's main roles was to support the GPs in providing older patients, particularly those living in care homes, with an effective service. Care home staff told us this arrangement worked well. The practice intended to audit the effectiveness of these developments in September 2015 but estimated that there had been a 30% reduction in requests for visits to care homes.

Two GPs at the practice had a specific interest in osteoporosis, a condition that affects the bones, causing them to become weak and fragile and more likely to break. They proactively followed up and monitored patients with risk factors such as early menopause or fractures to identify and support patients who had this condition and identify those who may be at risk. Individual appointments were arranged throughout the year and the practice also held osteoporosis clinics twice a year. The practice had scored 6.6% above the CCG average and 16.6% above the England average in QOF for prevention of fractures due to patients having fragile bones. The practice had completed an audit of patients to identify risk factors and produced a list of suggestions for the effective treatment of these patients. However, this audit was not dated. The practice was involved in a falls pilot with Warwick University which evaluated the effectiveness of primary care fall prevention interventions. This had looked at the impact of patients receiving advice only, advice with exercise and advice with Age UK support. They were waiting for the findings but hoped to gain evidence regarding the signposting of patients to the correct service for them.

Patients with mental health needs received an annual health check and QOF data for January 2013 to March 2014 showed that 75.95% had an agreed care plan which was below the national average of 86.04%. The practice had recognised the need to improve in this area and appointed a lead partner to look at all aspects of mental health in particular mental health reviews and follow up appointments.

The practice had identified patients who were living with dementia, including many of those in the care homes they visited. Data from QOF showed that during the 12 months ending 31 March 2014 93.55% of patients living with dementia had been seen in person for a review of their care and treatment compared with the national average of 83.82%.

Good

Are services effective?

(for example, treatment is effective)

The practice had systems for contacting patients living with long term conditions to attend the practice for their reviews. Patients with more than one condition which needed monitoring had one appointment where their overall health was checked so they did not need to visit the practice more than once. The practice was aware that its QOF results were lower than the national average in a number of areas (and in particular for diabetes management) and told us they had made changes that would improve this. The IT manager had created a dedicated system for arranging review appointments for patients and designated staff now contacted patients about their recall appointments. The practice told us this resulted in a rapport being developed with patients who were then less likely to miss appointments. The unpublished 2014/15 QOF data for the practice showed that they had achieved 90% of the available points for diabetes compared with 73% the previous year.

The practice recognised the importance of helping patients avoid unplanned hospital admissions. Data for the period October 2013 to September 2014 showed that fewer patients with a specified range of conditions had emergency hospital admissions than the national average (65.83% compared with 91.37%. The practice's figures for accident and emergency admissions was 249 compared with the national figure of 332. The practice team carried out a daily review of all hospital discharges and the nurse practitioner phoned all patients discharged from hospital.

The practice provided in house spirometry for patients with asthma and chronic obstructive airways disease. A spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function. Emergency admission rates for chronic obstructive pulmonary disease (COPD) were below the national average. For the period October 2013 to September 2014 5.26% of the practice's patients with COPD were admitted compared with the national figure of 12.88%. However, although during the same period the practice's asthma admission figure was 3.18% compared with the national figure of 1.95%.

The nurse practitioners carried out the annual reviews for patients with learning disabilities including those living in three care homes and booked longer appointments for this based on individual need. The practice had formats which were suitable for some patients' communication needs although care home staff told us some people's communication needs meant these could not be used. We spoke with senior staff from two of the homes who confirmed that patients had annual reviews, health checks and flu vaccinations.

The practice had a register of their patients who were receiving care and treatment at the end of life so the team were aware of these patients and could respond promptly when needed. The team told us that palliative care was a priority and that they worked closely with staff from a local hospice.

During 2014 the practice appointed a prescribing pharmacist for 30 hours a week. Their role included medicines reviews and the practice told us they completed 17% more medicines reviews in the first three months of 2015 compared with the same period in 2014. The pharmacist had done 90% of these which had increased the number of appointments available for patients who needed to see a GP by an average of 80 a week across both sites. The pharmacist also ensured that changes to patients' medicines while in hospital were rapidly and correctly updated in the practice records when they were discharged. Patients received their medicines faster because the turnaround time for repeat prescriptions had reduced from 72 hours to between 24 and 48 hours.

The pharmacist worked with the GPs and nurses to arrange blood tests and electrocardiograms before patients had their annual review appointments so the results of these were available for them to refer to. They also followed up patients discharged from hospital to help ensure that medicines changes were correctly updated in their records. We noted that the practice's prescribing of a specific group of antibiotics which should not be over prescribed was lower than the national average during the period 1 January 2014 to 31 December 2014 (2.94% compared with 5.33%). Prescribing of certain non-steroidal anti-inflammatory medicines which should be prescribed with caution was also lower than the national average during the same period (73.81% compared with 75.13%).

The practice had introduced a repeat dispensing process so patients for whom it was suitable could obtain an ongoing supply of their prescribed medicines for a period of time (assessed by their GP) without needing to request repeat prescriptions. The practice had produced a leaflet to explain this to patients. They also used advice slips to highlight messages to patients rather than relying on the information printed on prescription counterfoils. The

practice believed many patients discarded these without reading them. There was a slip for advising patients of specific messages from the GP or pharmacists, one for identifying concerns about a repeat prescription request and one for informing patients that their medicines review was due. This final slip had a selection of options for pre-review appointments with the healthcare team, practice nurses, nurse practitioners or GPs and what the appointment would be for (for example, blood pressure checks, blood tests or spirometry).

The practice hosted an in-house ultrasound service one day a week which was commissioned by the CCG. Appointments were available within one week. We learned of an example where a patient had been examined and a concerning swelling noted. They had a scan one week later and were then referred under the two week cancer referral guidelines with the scan results already available for a specialist to see. The practice also hosted physiotherapy and podiatry clinics. Enabling patients to access these services at the practice reduced referrals to secondary care.

Clinical audits are a process by which practices can demonstrate ongoing quality improvement and effective care. The practice provided us with examples of three audits. These related to impaired glucose tolerance, breast referrals to secondary care and osteoporosis. These audits were not dated but the practice told us these were ongoing audits repeated annually and related to 2014. The April 2014 cycle of an osteoporosis audit first completed in March 2013 highlighted that the practice needed to be more proactive in reviewing the medicines of some patients who might be at risk of developing the condition. This did not go on to describe whether this had happened and what the subsequent findings and actions were. This was also the case with a breast referral audit carried out in May 2014 which the practice were about to repeat. Another audit from February 2014 in respect of home visits which explored the relationship between the numbers of visits, the age of patients and the impact of a GP telephoning patients to check whether a visit was urgent or necessary. However, this audit had not yet had a second cycle. The practice informed us of several further audits which were in progress.

Effective staffing

The practice told us that they had experienced a number of changes in the last two years including the retirement of two senior partners and a long standing practice manager. To ensure they made the right appointment the practice had employed a temporary practice manager for nine months before then appointing the current post holder. This gave them time to look for the candidate they felt would fit best with their vision for the future of the practice.

The practice had an experienced and skilled staff team with clear roles and responsibilities. Nurses at the practice told us that the partners were very supportive and encouraged them to complete additional training to develop their skills and expertise. They confirmed that they received regular appraisals and had protected learning time to help them maintain their continuing professional development (CPD). The practice manager had a system for checking that the clinicians' professional registrations remained up to date and valid.

The GPs and nurses at the practice had a wide range of knowledge and skills. Their knowledge and skills were updated with ongoing accredited training and in-house training. Between them the nursing team had completed a wide range of training to enable them to support patients with a range of long term conditions including diabetes, asthma, COPD and heart disease. Some were trained to manage the treatment of patients taking blood thinning medicines, carry out cervical screening and provide treatment for complex leg ulcers. The GPs had a range of areas of interest and expertise including minor surgery, women's health and contraception, safeguarding, palliative care, learning disability, mental health, dementia, dermatology and several others.

The practice had two nurse practitioners who were qualified to master's degree level and another who was trained to be able to prescribe a defined range of medicines. One of these nurses was the lead nurse for older patients and avoiding unplanned admissions for them and for other patients with complex care and treatment needs. They were involved in preventative care with patients with heart disease related circulation problems and were also trained to provide contraceptive advice. A named GP was responsible for mentoring nurse practitioners in respect of their extended role.

The GPs took part in required annual external appraisals and had been revalidated or had a date for this. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has

Good

Are services effective?

(for example, treatment is effective)

been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England. The GPs had protected learning time to support them in maintaining their CPD.

The practice manager had a system for recording and monitoring training for the staff team. This showed that staff were up to date with attending mandatory courses such as safeguarding and basic life support. We noted that there was an induction checklist but this was very brief.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Staff were knowledgeable about the practice's systems for making sure results were seen and dealt with promptly by the GPs and that patients were informed of their results.

The GPs took part in weekly multi-disciplinary team meetings with other relevant professionals and alternated the venue between the main practice and the branch surgery. Other professionals at the meetings included local health visitor teams and representatives from the local carer support organisation where appropriate. Staff told us that the practice benefited from having health visitors and school nurses based within the same building which made it easy and convenient to speak with colleagues whenever necessary.

We spoke with senior staff from six of care homes for older people. They described a positive working relationship with the practice team. They told us the practice manager had initiated meetings to improve communication between the practice and the homes. The managers who had taken part in these meetings had found these very positive. The homes confirmed that the nurse practitioners and GPs worked in partnership with them to improve the overall medical care that patients received. One manager gave an example of a GP timing a visit to fit in with a social worker's availability. This had enabled a multidisciplinary approach to a specific decision about that person's care. Senior staff we spoke with from two learning disability care homes also confirmed that the practice communicated with them well although they were not involved in the same meetings as the care homes for older people.

The practice worked in partnership with workers from Gateway in Worcestershire. Gateway workers are qualified mental health practitioners, experienced in the assessment and treatment of mental health problems. They have skills, experience and knowledge which enable them to assist people to deal with a wide variety of mental health problems and, where appropriate, with related social and family issues.

Information sharing

The practice had a process for making sure test results and other important communications about patients were dealt with promptly. Arrangements were in place for the practice to provide information about patients with complex care needs, such as those receiving end of life care, to the out of hours and ambulance services. This included the use of summary care records and emails to ensure specific information was passed on.

Staff were confident about using the practice's various electronic systems and said they were trained well. The practice team had a member of staff who provided in house IT support to assist with this.

There were designated staff to type and send referral letters from the GPs to secondary care services and there was a system to make sure this was done promptly and took into account how urgent a referral was. Patients were also able to use the Choose and Book service if they wished to.

The practice used an additional feature to their computer system to allow them to consult with each other with greater flexibility. The system provided a secure electronic system to help the GPs and other team members to manage, share and discuss matters relating to patients and the running of the practice. The system allowed them to have discussion without needing to be in the same room or having to use the telephone or email. They also used internet based calendars to help them share individual schedules and manage practice meetings.

Consent to care and treatment

The practice had a policy to support staff in fulfilling the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff were aware of the policy and showed us that this was available on the shared area of the practice computer system where they could all access it.

Good

Are services effective?

(for example, treatment is effective)

The GPs and nurses we spoke with understood the importance of gaining informed consent and had completed training about the MCA. Some staff we spoke with gave us examples of situations where they were aware that careful consideration of consent issues was particularly important. This included when they carried out procedures for patients with learning disabilities or those living with dementia.

Staff from local care homes confirmed that the practice was sensitive to the needs of patients living with dementia and who had learning disabilities and involved appropriate people in discussions about patients who were assessed not to have capacity to make specific decisions themselves.

The practice had a consent policy which provided guidance for GPs and nurses with duties involving children and young people under 16 in respect of the need to consider Gillick competence. The Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

The practice had an informative website which provided links to news and information about a wide range of health and care topics and could display the information provided in 90 languages.

The practice nurses, healthcare assistants and phlebotomist provided a range of appointments. These included women's health, blood tests, NHS health checks for 40 to 74 year olds, baby immunisations and health reviews for patients with long term conditions. Patients were also offered support to stop smoking although QOF data showed that the practice was recording the smoking status of fewer patients than the national average (79.45% compared with 86.63%). All new patients were booked to see one of the healthcare team for a health check.

The practice provided family planning advice and women could have long acting contraceptive devices and implants provided at the practice. Midwives and health visitors were based within the same building as the practice so that pregnant women and families with babies and young children could access all their healthcare in one place. There was a noticeboard in the waiting room with information from the local health visitor team about services for families and children including breast feeding and parenting advice, health visitor services and post natal support groups.

Childhood immunisation rates were one to three percentage points higher than the local CCG average for all except two immunisations. One of these was the same as the national average and one was 1.6% lower. The practice encouraged patients to have annual flu vaccinations and arranged flu clinics on six Saturdays to increase the availability of access for this. National data showed that the practice was lower the national average for providing flu vaccinations to patients under 65 who were at increased risk (47.48% compared with 53.22%) and for those over 65 (70.6% compared with 72.99%).

The practice nurses were responsible for the practice's cervical screening programme, including for women staying at a local hostel. They explained that they tried to maintain contact with these women at least until they had received the results of screening which were normally available within two weeks. The data we reviewed showed that in the last five years 86.9% of women aged between 25 and 64 had been screened compared with the national figure of 81.88%.

The practice team recognised that patients experiencing poor mental health were often reluctant to engage with health care services. The practice therefore used all opportunities to provide these patients with all the health checks and screening they needed on any occasion they attended the practice. The practice arranged home visits for patients who found going to the practice too challenging.

The health care assistants provided dietary advice and the practice had been involved in a scheme to provide vouchers for patients to attend 12 sessions with a national weight loss support scheme. This had been arranged by the CCG but had been discontinued. The practice felt that the scheme had helped patients and so had plans underway to start their own healthy lifestyle classes in partnership with a local fitness trainer.

The practice website contained links to NHS travel health information and patients could book appointments for travel vaccinations with the practice nurses on days and times convenient to them.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We gathered the views of patients from the practice by looking at 22 Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with three patients.

The data available from the NHS England GP patient survey when we planned the inspection showed that 85% of patients who responded had scored the practice good or very good for overall experience (85%). This was the same as the national average. In respect of being treated with care and concern by the practice nurses the practice had scored 93% compared with the national average of 90%. The score for care and concern shown by GPs was lower than the national average at 81% compared with 85% and 93% had confidence and trust in their GP compared with the national average of 95%.

The information patients gave us presented a positive picture of their experiences at the practice. Some commented that staff were always helpful and several mentioned being treated in a kind and caring way. Others described the team as polite, courteous, informative and sympathetic. One person highlighted that they appreciated the positive attitude of all members of the practice team and several used the comment cards to express their thanks to the practice for the care and treatment they received.

The practice provided primary medical care to patients living in seven care homes for older people and three for patients with learning disabilities. We spoke with the managers or senior staff from nine of these homes. They confirmed that the GPs and nurse practitioner were caring and respectful towards patients. Several highlighted that the GPs and nurse were excellent at communicating with patients living with dementia.

During the inspection we saw that reception staff followed the practice's confidentiality policy and were careful to respect patients' privacy in the reception area. There was a sign on the reception desk to inform patients that they could ask to speak with a receptionist in a more private area if they wished to.

Care planning and involvement in decisions about care and treatment

Some patients specifically mentioned that their GP listened to them and said they received prompt care and attention when this was needed including during long periods of being unwell. All of the patients who filled in cards indicated that they were happy with the care, treatment and support the practice gave them or members of their family.

The data available from the NHS England GP patient survey showed that patients had scored the practice higher than the national average (86% compared with 82%) for the GPs involving them about decisions about their care. Results were also higher than the national average for GPs giving them enough time (92% compared with 87%) and 90% said their GP was good at explaining test results and treatments compared with the national average of 86%. The data for the practice nurses was also positive and either the same as or slightly above the national average. For example, 90% said their nurse was good at involving them in decisions about care and treatment compared with the national figure of 85%.

Many of the patients in care homes were living with dementia. Some of the homes had particularly noted that the nurse and GPs worked hard to involve those patients as fully as possible in discussions and decisions about their care and treatment. They said the GPs had a good rapport with those patients and took their time and persevered rather than just asking staff for information straight away. The staff from the homes confirmed that when patients were unable to be involved the GPs worked with families and other people involved in their care to ensure that decisions were made in their best interests. Staff from the learning disability services we spoke with also described ways the GPs and nurses involved patients in their care and treatment and told us they communicated directly with the patient as far as this was possible.

Patient/carer support to cope emotionally with care and treatment

The information contained in the comment cards showed that patients felt supported by the practice. Patients told us that the staff had been kind to them and one described the friendly and pleasant way they had been supported during an extended period of treatment.

The care home staff we spoke with told us that the nurse and GPs were supportive of patients' families and always

Good

Are services caring?

prepared to spend time with them to discuss the care and treatment of their relative. One care home manager said the practice always rose to the occasion, particularly when a patient was nearing the end of their life and families needed additional support and information. Senior staff from another care home gave us an example of a patient who needed a procedure but were anxious and did not understand it. They told us a GP and a nurse worked in partnership with them for over three months to help the person understand by introducing the necessary equipment to them gradually. As a result the patient was no longer anxious and had this procedure whenever it was necessary.

The practice had a designated notice board in the waiting room for patients who were carers. This provided information for child and adult carers and included the contact details for the Worcestershire Carers' Association. The practice identified patients who were also carers and directed them to the association for advice and support. The practice invited a member of the organisation to their weekly multi-disciplinary team meetings and provided a room for a carer support worker to see carers at the practice. The practice documented relevant information about patient care and carers' needs provided by the carer support worker when appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was working in partnership with Age UK on an over 75s care project aimed at identifying and addressing unmet social need and had a member of the team with responsibility for co-ordinating this. The practice hosted a monthly Age UK clinic at the branch surgery to make it easy to refer patients to see one of their team about non-medical concerns. The practice told us this clinic was always fully booked. Patients had emailed the practice to thank them for putting them in touch with Age UK and gave examples of help they received. This included help with Blue Badges, personal independence payments and referrals to Age UK dementia services.

The practice had identified patients at the practice with specific care needs including those living with long term conditions, dementia or other mental health conditions and those nearing the end of life. Services were tailored to their needs. For example, patients with more complex or multiple health needs were offered longer appointments. We learned about the flexibility shown to a patient with very specific needs which made visiting the practice very challenging for them. In addition to booking longer appointments for this patient the staff went out of their way to help them manage their experience during their visit to the practice.

Three of the GPs were trained to use a dermascope, specialist equipment used to assist improved accuracy of diagnosis of skin conditions including melanoma, the most serious type of skin cancer. The practice had a service level agreement with another Worcester practice to provide dermatology service to their patients. The practice held one full dermatology session each week and appointments for dermascope examinations were available within one week. Patients received appointments for removal of skin lesions within three weeks. The practice planned to add an additional session to reduce the waiting time. The practice were about to extend the services they offered to other practices including minor surgery and the provision of long acting contraceptive implants and devices.

The practice had inherited a large number of patients with complex needs when another local practice re-located to an area where public transport was limited. The main surgery was close to the University of Worcester campus and told us they usually had large numbers of students registered with them.

Staff from care homes for older people confirmed that the practice responded positively when asked to visit as well as carrying out regular weekly visits. Two specifically mentioned the service patients received from the nurse practitioners who visited to see patients with minor illnesses. The practice had a designated telephone number for the care homes to use to make it easier for them to get through to the practice. Some of the homes mentioned that they could fax requests for visits to the practice which meant they did not have to spend time on the telephone. Staff at the learning disability services told us they usually took people to the practice for their appointments and generally found staff helpful and understanding. One mentioned that the length of time sitting in the waiting room could occasionally be difficult to cope with for the people they supported. We suggested they speak with the practice manager about this.

Tackling inequity and promoting equality

The practice building was purpose built and all patient areas were on the ground floor. There were automatic entrance doors to make it easier for patients with mobility difficulties and families with prams and pushchairs to get in and out of the building. The building had been designed to assist patients who used wheelchairs. The practice had a car park with spaces for patients with disabilities near the entrance.

The practice registered people staying at a local hostel as temporary patients. They viewed the provision of healthcare to these patients as a high priority due to their potential vulnerability and reception staff were aware to be flexible about arranging their appointments. The nurses explained that one challenge was being able to follow up test results and ongoing treatment with these patients but did their best to do so. For example, women were encouraged to find out the results of cervical screening before they moved on.

The practice had access to a telephone interpreting service for any patients who were unable to converse in English but staff told us that they did not need to use this very often. The practice website had a translation service which patients could use to translate all of the content into their preferred language. GPs also had the facility to print up to

Good

Are services responsive to people's needs?

(for example, to feedback?)

date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this. Cultural diversity was covered in the practice's induction and training materials and equality and diversity training was scheduled for 2015.

The practice had an induction loop to assist people who use hearing aids but this was not advertised on the practice website or the practice's NHS Choices pages.

Access to the service

The practice had an 'advanced access' system for patients to telephone early in the morning for an appointment the same day. As far as possible they tried to meet requests for patients to see the GP or nurse they chose. When no routine appointments were left for that day, patients who needed an urgent same day appointment were booked in to see the duty GP. The practice offered pre-bookable appointments with the GPs two weeks in advance (or further ahead in specific circumstances) and with the practice nurses up to four weeks in advance.

The practice had extended their hours to provide appointments for patients unable to come to the surgery during the main part of the day. The practice told us that this provided 525 additional appointments each quarter. GP appointments were available at 6.30pm and 6.40pm Monday to Thursday and up to 6.30pm on Fridays. Nurses' appointments were available at 7.40am and 7.50am each day. The practice also provided appointments with GPs and nurses on one Saturday a month. These were for pre-booked appointments for blood pressure checks, smoking cessation advice and diabetes reviews. Appointments for children were available outside school hours and the practice gave priority to seeing young children on the day. Additional capacity for this was provided by the three nurse practitioners who were able to see adults and children with minor ailments. One of these nurses was also a nurse prescriber who was able to prescribe certain medicines. The practice had plans to recruit two more nurse practitioners to provide additional capacity. The practice had appointed a prescribing pharmacist and this had also improved the availability of GP appointments. This was because the pharmacist was completing 90% of routine medicines reviews which freed an average of 80 GP appointments each week across both sites. In addition the turnaround for repeat prescription requests had been reduced from 72 hours to between 24 and 48 hours.

The practice started answering the telephones at 8am. They had employed additional staff to improve call answering. This was in response to patient concerns that they could not always get through on the telephone. For example, the most up to date NHS England GP survey information from 275 patients showed that 68% found it easy to get through on the telephone compared with the national average of 74%. However, 92% of patients were able to get an appointment to see or speak to someone the last time they tried compared with the national average of 85% and 95% said the last appointment they had was convenient compared with the national average of 92%. The practice had carried out their own survey in February 2015 with similar results and had work underway to make further improvements where needed. These included adjusting staff rotas to meet periods of highest incoming calls and changing the options on the answering system to filter patient calls more efficiently.

The practice worked in partnership with a local voluntary group who provided low cost transport for patients with identified difficulties getting to the practice for appointments.

The practice had an information leaflet and practice website providing a range of information about the team at the practice, opening times, the appointment system and internet booking.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were generally in line with recognised guidance and contractual obligations for GPs in England but still referred to the primary care trust (PCT) a commissioning organisation which no longer exists. There was a designated responsible person who handled all complaints in the practice. The practice manager had records showing that the practice identified themes that emerged from complaints to help them make improvements. We saw that there was a separate complaints leaflet tailored for patients with learning disabilities.

We identified examples of the practice making improvements as a result of learning from complaints. For example, following a complaint from a patient who was distressed about information they were given over the telephone the practice had adopted a policy to always give concerning information during face to face appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Another complaint was due to a delay in a patient's tests being carried out because a label fell off a blood sample. Following this the practice reviewed and changed their systems for labelling samples.

The practice manager told us they and one of the senior partners had face to face meetings with any patients who made a complaint. They had been doing this for a year and had seen a significant improvement in the satisfactory resolution of complaints because it was a more effective way to ensure patients felt that the practice had listened to them.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice told us that they had experienced a number of changes in the last two years including the retirement of two senior partners and a long standing practice manager. They had also inherited a large number of patients with complex needs when another local practice re-located. These issues had created challenges for the practice in the short term which they believed they were well on the way to overcoming. The partners and new practice manager were committed to improving the service and strengthening all aspects of the service to ensure that the practice was able to meet future challenges. The practice team were aware of the value of continued development and improvement and were optimistic about the future of the practice.

A new practice manager, new GPs and new nurses had been appointed and the practice was working to improve all its underpinning processes such as those relating to human resources. The practice had recently introduced new staff rotas, improved staff contracts and a training programme staff could access on their computers but also on their smart phones and tablet computers to make it more convenient for them to access online training. The partners believed that morale had improved and told us that the staff team had worked together to implement the changes.

Governance arrangements

The practice had a range of policies and procedures which were all available on the practice computer system where everyone in the practice team could access them. All of the staff we met understood their roles and responsibilities within the practice.

The practice held a variety of regular meetings and events to provide opportunities for communication, team building and shared education and learning. These included informal meetings every morning when the GPs met for a mid-morning break. The practice held weekly multidisciplinary meetings with other professionals, monthly partners meetings and quarterly clinical governance meetings. The partners' meeting were held in the evenings so that they did not impact on the availability of appointments. The nursing and healthcare team met monthly. We saw evidence that information from the meetings was recorded, shared with appropriate staff and saved for future reference. Other meetings were arranged when needed for specific topics. For example, a meeting was arranged to discuss changes to the medicines related policies made by the prescribing pharmacist.

The GP partners and nurses all had lead roles and specific areas of interest and expertise. These roles included specific lead roles at the practice such as minor surgery, women's health and contraception, safeguarding, palliative care, learning disability, mental health, dementia, dermatology and several others. The prescribing pharmacist was the lead for prescribing and medicines management. Some of the GPs also took the lead in non-clinical areas such as finance and human resources. The practice manager was the lead for their local practice manager peer support group.

The practice was aware of legal requirements in respect of patients' confidential information and information about this was available for patients in the practice leaflet. Electronic information was securely backed up off site and paper records were stored securely. Confidentiality and information governance were covered during staff induction and training.

Leadership, openness and transparency

Staff we spoke with during the inspection were positive about working at the practice and said they felt valued and appreciated in their roles. Twenty four of the 50 staff had been employed there for over 10 years. They described the whole team as approachable and supportive and said there was an 'open door' policy.

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

The practice had a patient participation group (PPG), a group of patients registered with a practice who worked with the practice team to improve services and the quality of care. This had been operating as a 'virtual' group using email for three years and had 10 members. The group's first face to face meeting was scheduled for the week after the inspection. Plans were actively underway for patients from local care homes to become members of the PPG and the practice had also encouraged patients who had previously made a complaint about the practice to become involved.

Are services well-led?

Good

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

We saw that the practice had information about joining the PPG and about the work it did on the practice website. This did not advertise the fact that the group would now be having face to face meetings to encourage additional patients to become involved.

In the NHS GP patient survey the practice had a lower than average score for getting through to the practice on the telephone. The practice had carried out their own survey in February 2015 with similar results and had work underway to make further improvements where needed.

Management lead through learning and improvement

The practice was monitored by the South Worcestershire clinical commissioning group (CCG) which undertook quality visits to practices in their area. The practice sent us their November 2014 report which identified areas progress made and actions which were in hand. For example, patients on a particular medicine had been reviewed and as a result prescribing of this medicine had been reduced appropriately.

During the inspection the practice team showed that they wanted to continue to develop and improve the service they provided. For example, the practice had recognised that they needed to improve their monitoring of patients with long term conditions and particularly those with diabetes. They had reviewed and improved the recall systems and assigned specific staff to be the first point of contact for them to improve communication about recall appointments. Other developments the practice planned to introduce included tablet computers to improve the availability and recording of patient information during home visits and remote healthcare monitoring systems. The practice had also identified that they needed to improve the clinical coding of patients' care and treatment to help ensure they had accurate data available and this work was underway.

Staff told us that the practice supported them to maintain their continuous professional development through appraisal, training and mentoring. Staff were supported to develop their knowledge and skills and this included protected learning time for all members of the practice team.

Severn Valley Medical Centre was a training practice for GP trainees. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. The practice was also a teaching practice and provided placements for medical students who had not yet qualified as doctors. The practice told us they only allocated two places at any one time to GP trainees and/or medical students so that their needs could be properly accommodated. The practice was in discussion with Worcester University about providing training placements for physician's associates. Physician associates are trained to perform a number of roles under the supervision of GPs who they support in the diagnosis and management of patients.