Pershore Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 19 May 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is outstanding. We found the practice to be good for providing safe, caring and well led services and outstanding for providing effective and responsive services.

The practice was outstanding at providing services for people with long term conditions and people in vulnerable circumstances. The practice was good at providing services for older people, families, children and young people, the working age population and those recently retired and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- There were systems in place to keep patients safe from the risk and spread of infection.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, with easy read information available for people with a learning disability to use should they prefer.
- The practice held regular multidisciplinary clinical team meetings to discuss the needs of complex patients, for example those with end of life care needs or children who were at risk of harm.
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

Summary of findings

- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

We saw several areas of outstanding practice including:

- Two new staff roles had been created (as part of a CCG led initiative utilising Avoiding Unplanned Admissions enhanced service funding) for patients in the community, a Care Home Advanced Nurse Practitioner (ANP) and a Community ANP. The care home ANP worked to reduce unplanned hospital admissions. This role was created 12 months ago and we saw evidence of the positive impact this had had for patients. As a result of this the practice has utilised funding to make this role a full time position. The community ANP arranged phone calls and or visits to frail and elderly patients, including those who were recently discharged from hospital, to assess their needs and offer support. This service, introduced in April 2015 has provided patients with health assessment, medical care and support within their home.
- The practice worked with the Worcestershire Alliance Board in partnership between Worcestershire Health and Care NHS Trust and South Worcestershire Healthcare as part of a Pro-Active Care Team (PACT). This team cared specifically for those patients who were on the unplanned admissions register to avoid further unplanned admissions to hospitals. Nationally reported data showed that the practice performed well against indicators relating to unplanned admissions. For the year ended March 2014 Pershore Medical Practice were 2% lower than the national average for admissions.
- A range of services were provided by the practice to meet the needs of patients with long term conditions. Three practice nurses were specifically trained in the management of diabetes care and this included a commitment to the Diabetic Expert Patient Programme which educated patients to manage their conditions. The practice was one of the highest performing practices in South Worcestershire for the care for diabetic patients. There was a high uptake of flu vaccines (99%) and foot examinations (93%) for diabetic patients.
- Pershore Medical Practice had looked for innovative ways to develop services for patients in their area. They had developed a project led by the practice manager at the practice, and initiated a meeting with two other local practices in the Pershore area. They had sought agreement to work together as a local cluster on a range of projects. The projects included shared skills and expertise and also involved working with members of the CCG and Age UK. As a result of this they had developed a shared referral process with another local practice where skills and expertise were made available to all patients at both practices. For example, one of the GPs provided a secondary Ear, Nose and Throat (ENT) service for both Pershore practices, principally dealing with ear infections and wax clearance where syringing may cause harm to the patient. The practice told us this provided a fast, flexible and local service as an alternative to hospital visits that ensured a better outcome for patients as they were able to access this service locally and promptly. The practice looked to extend these services for patients early in 2015.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Risks to patients were assessed and well managed. There were robust safeguarding measures in place to help protect children and vulnerable adults. Reliable systems were in place that ensured the safe storage and use of medicines and vaccines within the practice. There was a designated lead to oversee the hygiene standards within the practice to prevent infections. Enough staff were employed by the practice to keep people safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings during our inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the clinical commissioning group (CCG) and nationally.

The practice's emergency admission rates for a number of long term conditions including chronic heart disease (3.7% compared to 7.5%) and chronic obstructive pulmonary disease (COPD) (4.6% compared to 12.88%) were significantly below the national average. The practice's review rates for COPD were also higher than the local and national averages (90% of patients with these conditions compared to national rate of 81.4%). Data showed that the practice was effective in supporting patients with diabetes to manage their health and had low accident and emergency admission rates.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. Any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams internally and externally to deliver positive health outcomes for patients.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Data for the year 2014 showed that patients reported they had a positive experience of the practice at 92%, which was above the national average of 85%. Patients' experience of making an appointment was reported as 93% which was also above the national average of 83%.

Feedback from patients about their care and treatment was consistently and strongly positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care. The practice offered open appointments for patients with hearing impairments as they recognised that patients may find it difficult to contact the practice by telephone.

The practice supported patients to have a forum where they could learn and share ideas that promoted their health. There was an active patient participation group (PPG) at the practice that directed its own agenda and focused on topics that mattered to patients. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Information to help patients understand the services available was easy to understand, with alternative formats available depending on the needs of patients. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice understood the needs of the population groups registered with them and were proactive in planning services to meet their needs.

The practice had made changes to the way it delivered services as a result of feedback from patients and from the Patient Participation Group (PPG). PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Changes included online booking for some nurse appointments, and the creation of two new staff roles (as part of a CCG led initiative utilising Avoiding Unplanned Admissions enhanced service funding) for patients in the community, a Care Home Advanced Nurse Practitioner (ANP) and a Community ANP. Their roles included arranging phone calls and or visits to patients who were housebound to assess their needs and offer support.

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Patients told us it was easy to get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had used a system of triage for many years and this was well established to improve access for patients.

The practice provided a range of services to meet the needs of patients with long term conditions. Three practice nurses were specifically trained in the management of diabetes care and this included a commitment to the Diabetic Expert Patient Programme which sought to educate patients to manage their conditions. The practice was one of the highest performing practices in South Worcestershire for the care for diabetic patients. There was a high uptake of flu vaccines (99%) and foot examinations (93%) for diabetic patients.

Nationally reported data showed that the practice performed well against indicators relating to the care of older people. The percentage of patients diagnosed with dementia whose care has been reviewed for the year 2014 to 2015 was 86% which compared with national rates of 83%. Practice data showed that of 108 patients with dementia on the practice register, medicine reviews had been carried out for 52% of these patients for this year so far.

Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice's vision was to develop a traditional general practice in a modern way that enabled them to provide the best care for all their patients. They aimed to achieve this using their knowledge, expertise, experience, high quality care record and positive engagement with the local health economy. Staff we spoke with were aware of this vision and showed a strong commitment to work to provide this level of service for all patients.

There were positive examples of how the practice's vision and ethos were implemented by the staff team working together to maintain high standards, deliver positive health outcomes for patients and foster a supportive work environment. We saw examples of how the staff team worked together and supported each other throughout the inspection. Quality performance data showed the practice was performing exceptionally high compared with local and national averages, achieving an overall score of 99.1% in the 2014 to 2015 year.

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Pershore Medical Practice looked for innovative ways to develop services for patients in their area. The practice had a shared referral process in place with another local practice where skills and expertise were made available to all patients at both practices. For example, one of the GPs provided a secondary Ear, Nose and Throat (ENT) service for both Pershore practices, principally dealing with ear infections and wax clearance where syringing may cause harm to the patient. The practice told us this provided a fast, flexible and local service as an alternative to hospital visits that ensured a better outcome for patients as they were able to access this service locally and promptly. The practice looked to extend these services for patients early in 2015. They had initiated a meeting with two other local practices to reach agreement to work together as a local cluster on a range of projects. The projects included shared skills and expertise and also involved working with members of the CCG and Age UK.

The practice carried out proactive succession planning to ensure that the quality of service they provided and the continuity of care for patients were maintained, developed and improved. Staff told us they were supported to train and develop beyond their roles and move into positions with greater responsibilities.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

This practice is rated as outstanding for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services for example, in dementia and end of life care. The practice had engaged in a locality project with Age UK. Patients were given appropriate support to enable them to live as independently as possible. Home visits to patients were made to assess their needs and provide information about additional support that may be available to them through a range of services and organisations (including the voluntary sector and charities as well as NHS organisations).

The practice had created two new staff roles (as part of a CCG led initiative utilising Avoiding Unplanned Admissions enhanced service funding) to achieve this outcome for patients in the community, a Care Home Advanced Nurse Practitioner (ANP) and a Community ANP. The care home ANP worked to reduce unplanned hospital admissions. This role was created 12 months ago and we saw evidence of the positive impact this had had for patients. As a result of this the practice has utilised funding to make this role a full time position. The community ANP arranged phone calls and or visits to frail and elderly patients, including those who were recently discharged from hospital, to assess their needs and offer support. This service, introduced in April 2015 has provided patients with health assessment, medical care and support within their home.

Nationally reported data showed that the practice performed well against indicators relating to the care of older people. The practice provided a responsive service to patients who lived in three local care homes and in a home for patients with specialist conditions. The practice maintained a register of all patients in need of palliative care and offered home visits and rapid access appointments for those patients with complex healthcare needs. Other professionals and practice staff had access to clear information about patients receiving end of life care so they were able to respond in the event that medical assistance was needed. The practice held regular multidisciplinary integrated care meetings where all patients on the palliative care register were discussed.

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

Summary of findings

for appointments. The practice had exceeded the national average for providing flu vaccinations to patients over the age of 65. Data for the year 2014 showed that 80% of patients had been given their flu vaccination compared with the national rate of 73%.

People with long term conditions

Outstanding ☆

This practice is rated as outstanding for the care of people with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice provided a range of services to meet the needs of patients with long term conditions. Three practice nurses were specifically trained in the management of diabetes care and this included a commitment to the Diabetic Expert Patient Programme designed to educate patients to manage their own conditions. The practice was one of the highest performing practices in South Worcestershire for the care for diabetic patients. There was a high uptake of flu vaccines (99%) and foot examinations (93%) for diabetic patients. Data showed that the practice was effective in supporting patients with diabetes to manage their health and had low accident and emergency admission rates.

The practice's emergency admission rates for a number of long term conditions including chronic heart disease (5.31% compared to 8%) and chronic obstructive pulmonary disease (COPD) (4.82% compared 12.88%) were significantly below the national average.

Families, children and young people

Good ●

This practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice provided childhood immunisations and appointments for these could be booked throughout the week to provide flexibility for working families. The practice provided a family planning service and a range of options for contraception. The GPs and nurses worked with other professionals where this was necessary, particularly in respect of children living in vulnerable circumstances.

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There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk of harm, for example, children and young people who had a high number of attendances at the accident and emergency (A&E) department of the local hospital.

The practice's triage system by the Advanced Nurse Practitioner (ANP) supported this group of patients as the practice found the type of health problems commonly experienced by children and young people were often acute illnesses or minor ailments which were efficiently and effectively dealt with on the day.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice offered extended hours appointments for three mornings each week and one evening on alternate weeks for advanced booking. The practice appointment system aimed to enable patients to speak directly with an Advanced Nurse Practitioner (ANP) on the telephone and arrange an appointment at a time to suit them or to have telephone consultations with a GP where this was suitable. Patients could also book telephone calls with a GP.

The practice offered a number of online services, including booking and cancelling appointments, requesting repeat medicines, sending secure messages to the practice, viewing medical records and updating patient details.

They also provided a full range of health promotion and screening clinics that reflected the needs of this age group. The practice nurses had oversight for the management of a number of clinical areas, including immunisations, cervical cytology and some long term conditions. The healthcare assistants led the smoking cessation clinics in the practice.

People whose circumstances may make them vulnerable

Outstanding

This practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with a learning disability. The practice was committed to

meeting the needs of vulnerable people and provided a caring and responsive service for them. Alerts were placed on these patients' records so that they could be prioritised for appointments and offered additional attention, such as longer appointments.

At the time of the inspection there were 28 patients with a learning disability on the practice's register and annual health checks had been completed with all of these patients. Comprehensive records were kept of these checks and where necessary referrals to other services were made for the patients if they needed additional or more specialised care and treatment.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Information was provided for vulnerable patients by the practice about how to access various support groups and voluntary organisations. For example, through leaflets, on screen information in the waiting area and on the practice's website. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff demonstrated to us they were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in both normal working hours and out-of-hours.

The practice engaged in a Shared Care service in conjunction with another practice to support patients who had substance misuse issues. Their aim was to help them in a positive way towards recovery and eventual discharge.

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 held a register of patients living in vulnerable circumstances including those patients with a learning disability and dementia.

The practice invited patients to attend for an annual health check. Longer appointments were arranged for this and patients were seen by the GP they preferred. The annual reviews took into account patients' circumstances and support networks in addition to their physical health. The percentage of patients diagnosed with dementia whose care has been reviewed for the year 2014 to 2015 was 86% which compared with national rates of 83%. Practice data showed that of 108 patients with dementia on the practice register, medicine reviews had been carried out for 52% of these patients for this year so far.

The practice had given patients experiencing poor mental health information about how to access various support groups and voluntary organisations. It had a system in place to follow up

Summary of findings

patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We reviewed 22 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that all but one of the comments recorded were extremely positive. Patients commented that they were given excellent care by everyone at the practice and that staff were helpful, friendly and listened to them. Patients told us they found the whole experience of the practice as always very good and that all staff listened to patients and helped in the best way. They also commented that they could always see a GP when they needed to. One patient had commented that the telephone system was problematic for them as it was always busy and that they had not always been able to see their own GP when they wanted to.

We spoke with six patients during our inspection. These patients told us they were very satisfied with the treatment they received from all staff at the practice. They told us that they were treated with respect and that staff were friendly and courteous. Some comments were made about the lack of contact from the practice when patients had returned home following discharge from hospital and we shared these with the practice team.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey dated March 2014 and a survey of patients undertaken by the practice during 2014. Results of the national survey showed the practice was generally above average for its satisfaction scores on consultations with GPs and nurses. The practice had a higher than average score in the last GP patients saw or spoke to was good at treating them with care and concern (95% compared with 89%); 86% described their experience of making an appointment as good compared with the national average of 75%; and 87% of the patients surveyed would recommend this practice to someone new to the area which compared with national average of 79%.

We spoke with the managers of two local care homes where some of the practice's patients lived. They told us the practice was excellent at responding to the needs of patients. They were very satisfied with the care and treatment patients received and felt able to contact the practice at any time should they have concerns about patients who lived in the care homes.

The evidence from all these sources showed patients were satisfied with the service they received, they felt that they were given enough time during their appointments and that they were treated with care and concern.

Outstanding practice

- The practice had created two new staff roles (as part of a CCG led initiative utilising Avoiding Unplanned Admissions enhanced service funding) for patients in the community, a Care Home Advanced Nurse Practitioner (ANP) and a Community ANP. The care home ANP worked to reduce unplanned hospital admissions. This role was created 12 months ago and we saw evidence of the positive impact this had had for patients. As a result of this the practice has utilised funding to make this role a full time position. The community ANP arranged phone calls and or visits to frail and elderly patients, including those who were recently discharged from hospital, to assess their needs and offer support. This service, introduced in April 2015 has provided patients with health assessment, medical care and support within their home.
- The practice worked with the Worcestershire Alliance Board in partnership between Worcestershire Health and Care NHS Trust and South Worcestershire Healthcare as part of a Pro-Active Care Team (PACT). This team cared specifically for those patients who were on the unplanned admissions register to avoid further unplanned admissions to hospitals. Nationally reported data showed that the practice performed

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well against indicators relating to unplanned admissions. For the year ended March 2014 Pershore Medical Practice were 2% lower than the national average for admissions.

- The practice provided a range of services to meet the needs of patients with long term conditions. Three practice nurses were specifically trained in the management of diabetes care and this included a commitment to the Diabetic Expert Patient Programme which educated patients to manage their conditions. The practice was one of the highest performing practices in South Worcestershire for the care for diabetic patients. There was a high uptake of flu vaccines (99%) and foot examinations (93%) for diabetic patients.
- Pershore Medical Practice had looked for innovative ways to develop services for patients in their area. They had developed a project led by the practice manager at the practice, and initiated a meeting with two other local practices in the Pershore area. They had sought agreement to work together as a local cluster on a range of projects. The projects included shared skills and expertise and also involved working with members of the CCG and Age UK. As a result of this they had developed a shared referral process with another local practice where skills and expertise were made available to all patients at both practices. For example, one of the GPs provided a secondary Ear, Nose and Throat (ENT) service for both Pershore practices, principally dealing with ear infections and wax clearance where syringing may cause harm to the patient. The practice told us this provided a fast, flexible and local service as an alternative to hospital visits that ensured a better outcome for patients as they were able to access this service locally and promptly. The practice looked to extend these services for patients early in 2015.

Pershore 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, a Practice Manager and a Practice Nurse specialist advisor.

Background to Pershore Medical Practice

Pershore Medical Practice is located in the town of Pershore in Worcestershire and provides primary medical services to patients within a catchment area of an approximate 10 mile radius of their location. The practice building is purpose built, with good facilities and is well equipped to treat patients and meet their needs. The building is the collaboration between GPs, a community hospital trust and a district council. The community hospital and the practice are housed in the same building which is beneficial to patients being able to get treatment closer to home.

The practice has five GP partners, three salaried GPs and a trainee GP. This includes three female GPs which provides a choice for patients. There is a management team which includes a practice manager, a nurse manager, a customer services manager and a systems and administration manager. The nursing staff team includes four advanced nurse practitioners, three practice nurses and three health care assistants. In addition there are dispensary, administrative and reception staff. There were 10,169 patients registered with the practice at the time of the inspection.

The practice is open from 8am to 6.30pm Mondays to Fridays and is closed at weekends. Home visits are available for patients who are too ill to attend the practice for appointments. There is also an online service which allows patients to order repeat prescriptions, access telephone triage, and make clinic appointments. Patients also have access to information such as immunisation history which is held in their medical records.

The practice makes more appointments available for working people. There are early morning appointments available from 7.30am to 8am on Tuesdays, Wednesdays and Thursdays. The practice provides alternate Monday evening appointments from 6.30pm until 7.30pm. All of these appointments have to be booked in advance. GPs and nurse practitioners are available for patients during these extended hours.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics such as asthma, diabetes, heart disease, well woman, and child and travel immunisation clinics. Other clinics include minor surgery, Shared Care for drug and alcohol abuse, minor injuries and smoking cessation.

The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed. If patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on the circumstances. Information on the out-of-hours service is provided to patients and is available on the practice's website.

Pershore Medical Practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Pershore Medical Practice is an approved training practice for doctors who wish to be become GPs. A GP trainee is a qualified doctor who is training to become a GP through a

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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 also offers placement opportunities for trainee nurses from the local university who may want to enter into general practice as a career.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before our inspection of Pershore Medical Practice we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted South Worcestershire Clinical Commissioning Group (CCG), NHS England Area Team and Healthwatch to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 19 May 2015. During our inspection we spoke with a range of staff that included five GPs, the practice manager, the systems and administration manager, nursing, administration and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with six patients who visited the practice during the inspection five of whom were members of the practice's patient participation group (PPG). We also spoke with the managers of two local care homes who gave us information about the service provided by the practice to patients living in those homes. We reviewed 22 comment cards where patients and members of the public shared their views and experiences of the practice.

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

- 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 patients and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We saw detailed records with comprehensive analyses completed by the practice in relation to reported incidents and complaints. These showed that all areas of reporting had been well managed and that the practice recognised the importance and the relevance in identifying risks and improving quality in relation to patient safety. Staff we spoke with understood the importance of recognising, reporting and recording significant events. They gave us examples of situations they had reported and that the practice team had discussed during meetings.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. These records showed the practice had managed these consistently over time and could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records available to show significant events that had occurred over several years. We reviewed those that had occurred during the last 12 months.

Staff used incident forms on the practice intranet and shared computer drive and sent completed forms to the practice manager. The practice manager showed us the system used to manage and monitor incidents. We tracked four such incidents recorded within the last 12 months and saw records had been completed in a comprehensive and timely manner.

We saw that significant events were discussed at the weekly practice meetings and minutes were circulated to staff. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists and nursing staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff told us they were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, we saw that an incident had been reported in 2014 regarding a vaccine which had been left out overnight and had to be destroyed as a result. We saw that action had been taken in response to this and a revised procedure was established to ensure there was no recurrence. We saw that significant events had been discussed at practice meetings which demonstrated the willingness by staff to report and record incidents.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with gave us examples of recent alerts that were relevant to the care they were responsible for. They also told us that alerts were discussed at the practice meetings to make sure all staff were aware of any that were relevant to the practice and any action that was needed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We discussed with members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, document concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible for staff.

The practice had a dedicated GP as the safeguarding lead for vulnerable adults and children. They had been trained and could demonstrate they had the knowledge and understanding to enable them to fulfil this role. All staff we spoke with told us they were aware who the lead was and who to speak to within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to a child protection plan. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as health visitors and social services.

There was a chaperone policy available to all staff on the practice computer. We saw that a poster informing patients about the chaperone policy was displayed in the reception

area. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Staff we spoke with told us that only clinical staff acted as chaperones when needed. Clinical staff told us they had received chaperone training and they were clear about their responsibilities. This included, for example knowing where to stand when intimate examinations took place. We saw staff training records to confirm this.

The practice had a whistleblowing policy which included information about the rights and responsibilities of staff. Staff knew that this was available on the practice computer system and told us that the team had discussed whistleblowing at staff meetings. Staff told us they would have no hesitation in reporting any concerns because they were confident they would be well supported by the practice.

Medicines management

We checked medicines stored in the treatment rooms, dispensary and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff were aware of the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. We saw that nurse practitioners who were qualified as independent prescribers had received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice processed, printed and signed prescriptions from a separate room. There was also a dedicated telephone line in this room where a member of staff took calls for prescription requests. Staff told us this had improved the management of prescriptions and allowed for focussed prescription processing without distractions. Discussion with the dispensing staff at the practice showed that they were aware prescriptions should be signed before being dispensed.

The practice had a system in place to assess the quality of the dispensing process. We saw the results of a dispensary survey carried out by the practice in February 2015 to determine patient satisfaction with the dispensing service. The results were positive with 96% commenting that the courtesy and professionalism of staff was excellent.

The practice had established a service for patients to pick up their dispensed prescriptions at the practice. They also had arrangements in place to ensure that patients collecting medicines from the practice were given all the relevant information they required. There was also a system in place to monitor that these medicines were collected with a procedure for staff to follow if medicines were not collected.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. For example, we saw certificates that showed all dispensers held appropriate qualifications in pharmacy services, such as those for dispensing doctor's assistants and a higher level pharmacy technician's course.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. This was confirmed by patient feedback through the comment cards.

One of the practice nurses was the lead for infection control and all staff had received infection control training and annual updates. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings for examination couches were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Good

Are services safe?

There was also a policy and guidance in place for a needle stick injury and staff knew the procedure to follow in the event of an injury. Guidance for staff was also clearly displayed in treatment rooms. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw evidence that regular infection control audits were carried out. The process consisted of annual audits, with three monthly audits planned to enable follow up on any actions identified. The most recent audit had been carried out on 6 May 2015. From this audit we saw that issues of concern had been recorded, with action taken to resolve these and a date and signature to confirm actions completed. For example, a tear had been identified on one of the examination couches and arrangements had been made for this to be repaired. We saw from meeting minutes that improvements identified had been discussed at team meetings.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and we saw stickers indicating the last testing date were displayed on equipment. We saw that a schedule of testing was in place.

Records confirmed that measuring equipment used in the practice was checked and calibrated each year to ensure they were in good working order. For example, we saw that annual calibration (testing for accuracy) of relevant equipment such as weighing scales, ear syringes, nebulisers and blood pressure monitoring machines had been carried out during 2014.

Staffing and recruitment

The practice had a recruitment policy in place. Records we looked at contained evidence that the practice had followed their policy and appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice had completed risk assessments for staff where they had not needed to do DBS checks. For example, those staff who never had unsupervised contact with patients. We spoke with staff who confirmed that all the checks had been carried out prior to their employment.

The practice had an experienced and skilled staff team with clear responsibilities and lines of accountability. The staff team were well established and many staff had worked at the practice for a number of years. We spoke with staff about the arrangements for planning and monitoring the number of staff and the mix of staff needed to meet patients' needs. We were told that the staff were flexible and covered for each other and would work additional hours if required. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the environment, medicines management and dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was the identified health and safety representative. The practice told us that they kept safety at the forefront of everything they did. They had engaged with an external consultancy firm to provide professional health and safety advice to the practice and a comprehensive up-to-date Health and Safety Management System.

The GPs and practice manager told us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients and babies and young children. Patients were offered appointments that suited them, for example the same day, next day or pre-bookable appointments with their choice of GP.

Staff told us they were able to identify and respond to changing risks to patients including deteriorating health

and well-being or medical emergencies. For example, staff explained how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

The practice told us that they aimed to continue with and further develop the system whereby patients with long term conditions such as coronary heart disease, heart failure and stroke were monitored and were annually recalled into their one stop clinic for heart and circulation diseases. The practice was proactively looking to improve their existing system for treating patients suffering from epilepsy, chronic kidney disease, mental health problems, depression and hypothyroid by ensuring they were carefully monitored by the clinical team through regular recall into practice clinics.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw evidence that basic life support training had been completed by all staff including reception staff. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with all knew the location of this equipment and records confirmed that it was checked regularly so that it was suitable for use at all times.

Emergency medicines were available in a secure area of the practice and staff spoken with knew of their location. These included medicines for the treatment of cardiac arrest (where the heart stops beating), a severe allergic reaction and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, loss of telephone system, loss of computer system, GP sickness and loss of clinical supplies. The document also contained relevant contact details for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, contact details of local suppliers to contact in the event of failure, such as heating and water suppliers. We saw there was a procedure in place to protect computerised information and records should there be a computer systems failure. The practice manager and GPs confirmed that copies of this plan were available to all staff on any computer within the practice, and copies of the plan were also held off site with designated management staff.

We saw evidence that staff took part in regular fire drills and fire training. The practice had a fire risk assessment in place dated September 2014 which was reviewed annually.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs that they completed assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. Shared records were in place to enable best practice guidance to be stored and shared by all staff. We saw copies of the guidance that had been circulated to clinical staff by email and minutes of practice meetings where new guidelines had been discussed and shared. Staff we spoke with confirmed this.

The clinicians we spoke with told us and meeting minutes confirmed that patients with new cancer diagnosis were discussed at clinical meetings to ensure the appropriate care and referral pathways were followed. This ensured that there were no delays to their care and treatment. The data quality report for 2014 showed that 85% of patients had been referred within the two week requirement, with explanations recorded for 15% of patients who were outside this time limit. For example, where a patient was unable to accept the first two appointments offered, or where patients cancelled appointments.

GPs at the practice each led in specialist clinical areas such as diabetes, palliative care, mental health, learning disabilities, dementia, women's health, lung diseases such as asthma, and minor surgery. The practice nurses supported this work, which allowed the practice to focus on the specific conditions. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG) and engaged in annual appraisal and other educational support.

The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. Staff told us that GPs were very approachable and that they felt able to ask for support or advice if they felt they needed it.

The practice gave us an example of their teamwork approach to providing effective care and treatment for patients. They told us about a patient who had attended a routine clinic with a health care assistant (HCA). During this clinical session the patient mentioned some symptoms they had experienced. The HCA carried out some additional tests to check these symptoms. The results were positive indicators for an undiagnosed condition. The patient was then referred to the specialist nurse within the practice. The specialist nurse was able to make a full diagnosis, commence treatment, provide information and advice and initiate a follow up plan with the patient. All this took place within one day and showed a positive outcome for the patient. Clinical staff we spoke with during the inspection described other situations where patients had accessed a number of services during a routine appointment.

The practice used mobile applications on their electronic tablets for visits to patients in their homes. This provided them with direct access to information about patients' medical history and enabled them to record clinical information about patients during visits.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that they encouraged a culture in the practice of patients cared for and treated based on need. The practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice routinely gathered information about people's care and treatment and monitored this in order to improve patient care. Staff across the practice had key roles in monitoring and improving outcomes for patients such as data input, scheduling clinical reviews, managing child protection alerts, medicines management, prescriptions management and infection prevention and control.

The practice had a system in place for completing clinical audits. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards were being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice showed us clinical audits that GPs had completed over a number of years, including four we looked at that had been completed more recently. Following each clinical audit, changes to treatment or care had been made where needed to ensure outcomes for patients had improved. For example, one of the audits we looked at had been completed because the practice had a higher than average rate of emergency admissions of patients with atrial fibrillation (irregular heartbeat) when compared with other practices within the CCG area. The audit was carried out in June 2014 and examined reasons for this and looked to see whether changes could be made to the management of patient care in order to prevent or reduce emergency admissions. The result of the audit and subsequent practice discussion recognised that changes to practice by clinicians would be beneficial to patients. This audit was well written and clearly showed the rationale for the audit, the results and the proposed changes to be made. A date for follow up audit was scheduled for June 2015.

A further audit carried out in April 2014 found that patients who used inhalers to help with their breathing had not had their technique reviewed by the nurse. The reviews were to ensure that patients operated good inhaler techniques so that they were not exposed to higher doses of medicine than they needed. A plan of action was devised and all nurses had completed training on the use of inhalers and inhaler technique by November 2014. A re-audit was carried out in March 2015 and found that 128 patients had been reviewed with results that showed improved outcomes for 44 patients. The practice determined that inhaler techniques were to become part of patients' annual review to ensure they were achieving the best results with the medicine they prescribed, or that the prescribed medicines were the most effective for the patients. The action plan identified that further more detailed audits were required to determine the type of inhalers prescribed, alternatives available and whether additional clinical training was required.

The practice told us that the local CCG had developed a program of monitoring and audit assessment called Improving Quality and Supporting Practices (IQSP). The practice told us this process had enabled them to bring many of their disparate audits and quality assessments into one place, which ensured a more effective practice-wide roll-out of any lessons learnt. We saw an example where the practice had been asked by the CCG to summarise its approach to their very low prescribing of an antibiotic medicine and share this as a top tip for other practices within the CCG area.

As part of the IQSP process the practice met bi-annually with the CCG to discuss these, interpret the results and plan future areas to consider. The practice had developed a spreadsheet to keep all of this information in one place so that it would be easily accessible. Dates when reviews of audits were due were highlighted to ensure re-audits were completed accordingly.

The practice also used the information collected for the Quality and Outcomes Framework (QOF), (a national performance monitoring tool) and performance against national screening programmes to monitor outcomes for patients. In most areas the practice had reached performance levels that were higher than the national average. For example, the number of patients with diabetes who had received their flu injection was 99% which compared with the national average of 93%. The practice had achieved 99% for their total QOF points compared with a national average of 94%.

The practice also kept registers of patients identified as being at high risk of admission to hospital as well as various vulnerable patient groups such as patients with a learning disability. One of the GPs had a specific interest in the needs of patients with learning disabilities and they carried out all of the annual reviews for those patients. Data showed 100% of annual reviews had been carried out in the last year for these patients. The GP we spoke with told us that review appointments were booked for 30 to 40 minutes to make sure there was enough time to speak with patients and explain things to them. They told us that this meant they had been able to establish relationships with those patients and they were more comfortable and willing to discuss their care needs with them. The practice used formats which were suitable for patients' communication needs and included pictorial prompts and short, easy to understand words and phrases.

The practice kept a palliative care register and held regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. All patients had up to date care plans and these were shared with other providers such as the out-of-hours service.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice had a proactive approach to the care of patients living with long term conditions. The practice carried out structured annual reviews for patients with long term conditions and contacted patients on their birthdays to arrange these review appointments. The practice had a process in place where patients with more than one long term condition were reviewed for all conditions at the one appointment rather than separate appointments for each condition.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system used at the practice flagged up relevant medicine alerts when the GP prescribed medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe these outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, dispensary, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training such as annual basic life support. We noted a good skill mix among the GPs who collectively had additional diplomas as medical education trainers, in learning disabilities, minor surgery, diabetes and family planning. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The dispensary team were responsible for the repeat prescribing service and dispensing medicines to patients who lived within the prescribing area of the practice.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. Staff told us that they had been given opportunities to develop careers within the practice. For example, having worked as a receptionist one person had now trained and was employed as a dispenser and another as a health care assistant (HCA).

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, vaccines, ear syringing, quit smoking programme and lifestyle advice. Those with extended roles such as monitoring patients with long-term conditions which included asthma, diabetes and heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Pershore Medical Practice was an approved training practice for doctors who wished to be become GPs. 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 also offered placement opportunities for trainee nurses from the local university who may be interested in working in general practice as a career.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with

other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings monthly (or sooner if required) to discuss the needs of complex patients, for example those with end of life care needs or children at risk of harm. These meetings were attended by health visitors and palliative care nurses. Decisions about care planning were documented in patients' records. GPs told us that they worked closely with the team to make sure patients' needs were met and that important information was shared. Staff also told us that members of the community team such as health visitors and district nurses would join the daily morning meetings if there was information they wanted to share or had concerns they wanted to raise ahead of the usual meetings.

The GPs provided a medical service to patients for the 26 bed local community hospital in collaboration with another local practice. This enabled patients to receive appropriate treatment closer to home. Managers of two of the local care homes where patients registered with the practice lived told us that patients received the care they needed and promptly when they needed it.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used mobile applications on their electronic tablets for visits to patients in their homes. This provided them with direct access to information about patients' medical history and enabled them to record clinical information about patients during visits.

Consent to care and treatment

We saw that the practice had a policy for documenting consent. We found that clinical staff we spoke with were aware of the Mental Capacity Act 2005 (MCA), the Children Acts 1989 and 2004 and their duties in fulfilling it. GPs told us they recorded decisions about consent and capacity in patient records and showed us an anonymised example to demonstrate this. The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance. They confirmed they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure where applicable. The clinical staff we spoke with understood the key parts of the legislation and they were able to describe to us how they implemented it in their practice. For example, staff told us that parental consent was sought prior to the administration of immunisations to children and was documented in the patient's record. We saw from training records that most clinical staff had completed training about consent. We saw that dates had been arranged for those staff yet to complete this training.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. Staff gave us examples of how a patient's best interests were taken into account if a patient did not have the capacity to make a decision. The GPs also demonstrated a clear understanding of Gillick competence. The 'Gillick Test' helps clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment. GPs confirmed that they always obtained written consent when they carried out minor surgery procedures.

The managers of two of the local care homes confirmed that the GPs understood the issues to be considered in respect of the MCA and worked with the staff at the home to deal with issues such as consent and decisions about end of life care in a sensitive way.

The practice had not needed to use restraint but staff told us they were aware of the distinction between lawful and unlawful restraint.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

It was practice policy to offer a health check with one of the nursing team to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, they promote the benefits of childhood immunisations with parents, or carry out opportunistic medicine reviews.

Staff told us they aimed to provide good chronic disease management, with patient education as the key to improvements in patient health. They told us that giving patients adequate guidance and education helped them to manage their own health. The practice was engaged in the Diabetes Expert Patient Program (EPP). Expert patients are defined as people living with a long-term health condition who are able to take more control over their health by understanding and managing their conditions, leading to an improved quality of life. The EPP provides courses which are designed to give patients with long-term conditions the tools, techniques and confidence to manage their condition better on a daily basis. The practice was a high performer in the South Worcestershire CCG area for the management of diabetic patients and staff told us they aimed to maintain this level of service. Data showed that the practice was effective in supporting patients with diabetes to manage their health and they had low accident and emergency admission rates. For example, there was a high uptake of flu vaccines (99%) and foot examinations (93%) for diabetic patients.

The practice attributed their high levels of expertise within their clinical teams in the management of asthma and chronic obstructive pulmonary disease (COPD) to their low emergency admission rates. The practice also had staff who were specifically trained in spirometry, a procedure to carry out tests on how well patients' lungs worked. The practice's emergency admission rates for a number of long term conditions such as chronic heart disease (5.31% compared to 8%) and chronic obstructive pulmonary disease (COPD) (4.82% compared 12.88%) were significantly below the national average. COPD is the name for a collection of lung diseases, including chronic bronchitis, emphysema and chronic obstructive airways.

The practice had numerous ways of identifying patients who needed additional support and it was pro-active in offering help. For example, the practice kept a register of all patients with a learning disability and ensured that longer appointments were available for them when required. Annual health reviews were also carried out for patients with a learning disability. We saw that health reviews had been completed for all 28 patients with a learning disability registered with the practice. Staff told us and records confirmed that a GP and a nurse were trained in supporting patients with a learning disabilities. They told us they had access to the community learning disability team as needed to support patients with learning disability registered with the practice.

The practice nurses we spoke with told us they carried out regular health checks of patients with range of long term conditions. They confirmed that meetings were held with the palliative care teams to ensure co-ordinated care was provided to patients that matched their needs and wishes. The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Clinical staff described the policy and procedure in place for following up patients who failed to attend these clinics. This was done by either the named practice nurse or the GP. The practice offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease.

The practice also offered NHS Health Checks to all its patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and described how they scheduled further investigations. Up to date care plans were in place that were shared with other providers such as the out-of-hours provider and with multidisciplinary case management teams. Patients aged 75 years or over and patients with long term conditions were provided with a named GP.

Last year's performance for cervical smear uptake was 80%, which was slightly below the national average of 82%. There was a policy to offer telephone reminders for patients who had not attended for cervical smears and the practice carried out annual audits for patients who failed to attend.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as the bereavement service Cruse. We saw that the practice had access to a range of support organisations that they were able to signpost patients to for further information.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction, taken from the national patient survey 2014 and complaints and compliments received by the practice. We also looked at the 22 Care Quality Commission (CQC) comment cards patients that we received where patients were invited to provide us with feedback on the practice. We spoke with six patients who attended the practice during our inspection. The evidence from all these sources showed that patients were generally satisfied with how they were treated and confirmed that this was with respect, dignity and compassion.

The data available from the NHS England GP patient survey showed that patients had scored above the national average. For example, 90% said the GP was good at treating them with care and concern compared to the national average of 85%; 91% said the GP they saw gave them enough time compared to the national average of 87%; 97% said the GP they saw was good at listening to them compared to the national average of 89%; and 99% that said they had confidence and trust in the GP which compared with 95% for the national average.

We looked at each of the 22 comment cards completed by patients who told us what they thought about the practice. All comments were extremely positive about their experiences of the service. One patient commented however that they were not always able to get through on the telephone as the phone lines were always busy, and they were not always able to see their own GP when they wanted to. Patients said they felt the practice offered an excellent service and that staff provided good care, were efficient and knowledgeable. They commented that all staff at the practice were excellent, very friendly and warm. Patients we spoke with were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We saw the rooms had appropriate couches for examinations and curtains to maintain privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that if patients wanted to speak to the receptionist or practice manager privately they would be taken to a private room.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Observation of and discussions with staff showed that they were compassionate and treated patients in a sensitive manner, particularly important for those patients whose circumstances may make them vulnerable such as temporary residents or patients who were experiencing mental health issues.

Staff told us they offered a chaperone service if patients preferred. We saw leaflets in the reception area and information on the practice website that confirmed this. Clinical staff confirmed they had received chaperone training. They told us that information was made available to patients to inform them of the option of having a chaperone present. When a chaperone had been offered information was recorded in patients' case notes and included where a chaperone had been declined.

There was information in the practice information leaflet and on the practice's website stating the practice's zero tolerance for abusive behaviour. Staff told us that there had been occasions when they had needed to refer to this to diffuse potentially difficult situations, but this had only been necessary on a small number of occasions.

Care planning and involvement in decisions about care and treatment

The 2014 patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions. For example, data from this national patient survey showed that 87% of practice respondents said the GP involved them in care decisions and 96% felt the GP was good at explaining treatment and results to them, which was higher than the national average of 89%. The proportion of

Good

Are services caring?

respondents to the GP patient survey who stated that the nurses were good at involving them in decisions about their care was 85% which compared with the national average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patient feedback on the comment cards we received was also positive and aligned with these views. Patients' commented that all clinical staff at the practice were particularly good when treating them and took the time to make sure they fully understood their treatment options.

We saw evidence of care plans and patient involvement in agreeing these. For example, patients with a learning disability were given longer appointments so that they could be given time to discuss their individual care plans. Other patients who were diagnosed with asthma, dementia and mental health concerns also had individual care plans. Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that they always encouraged patients to make their own decisions. They told us that they would always speak with the patient and obtain their agreement for any treatment or intervention even if they were with a carer or relative. The nurses told us that if they had concerns about a patient's ability to understand or consent to treatment, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals.

Patient/carer support to cope emotionally with care and treatment

Feedback from patients showed that they were positive about the emotional support provided by the practice. For example, one patient wrote in the comment cards that they thought the practice was wonderful and staff always seemed to go the extra mile in giving them the help they needed. They commented that staff were caring and supportive throughout. Comments from other patients we spoke with during our inspection and the comment cards we received were also consistent with this feedback. Patients told us that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations including how to get benefits advice. This included details of various support groups and organisations for carers and families. Patients who were carers were encouraged to register so that the practice were aware of their role and could direct them to local carers' organisations for practical support and advice. The practice's computer system alerted GPs if a patient was also a carer. Information about local health and social care organisations and sources of support and guidance was available on the practice website and at the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs of patients. Staff told us the practice population consisted of a higher number of older patients. For example, national patient data 2014 showed that the number of patients in the over 65 years of age population group registered with the practice was 28% compared with the national average of 17%. The population group of patients over 75 years of age registered with the practice was 13% compared with the national average of 8%.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population. The practice GPs were strongly involved and engaged with their local CCG and the Local Medical Council (LMC). They were keen to be involved in local initiatives and in sharing good practice. One of the practice partners was an active lead member of the CCG and also the constituency representative for the LMC. Another of the practice's GPs was a GP trainer and education lead, involved in recruiting and developing training opportunities for doctors, medical students and student nurses. They had also developed an educational and developmental structure within the practice for existing nursing staff.

We saw that Pershore Medical Practice looked for innovative ways to develop services for patients in their area. The practice had a shared referral process in place with another local practice where skills and expertise were made available to all patients at both practices. For example, one of the GPs provided a secondary Ear, Nose and Throat (ENT) service for both Pershore practices, principally dealing with ear infections and wax clearance where syringing may cause harm to the patient. The practice told us this provided a fast, flexible and local service as an alternative to hospital visits that ensured a better outcome for patients as they were able to access this service locally and promptly. The practice looked to extend these services for patients early in 2015. They had initiated a meeting with two other local practices to reach agreement to work together as a local cluster on a range of projects. The projects included shared skills and expertise and also involved working with members of the CCG and Age UK.

The practice told us they also planned to look at ways in which the patient participation group (PPG) could work in similar cluster arrangements across these practices to share knowledge, experiences and information. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The purpose of the PPG is to discuss the services offered and discuss how improvements could be made to benefit the practice and its patients.

The practice delivered core services to meet the needs of the patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and lung disease. The practice explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions. Longer appointments were available for patients who needed them such as patients with mental health concerns, learning disabilities and long term conditions.

The practice had a palliative care register and regular multidisciplinary team meetings (MDTs) were held to discuss patient and their families care and support needs. We were told by staff that the MDTs worked very well as a team to provide care for all patients.

The practice implemented suggestions for improvements and made changes to the way it delivered services as a result of feedback from patients and from the PPG. As a result of patient feedback, online booking had been activated by the practice for some nurse appointments. Six nurse appointments a day had been made available and the number of appointments which patients could book with GPs online had also been increased.

In response to feedback from the PPG the practice had also created two new staff roles (as part of a CCG led initiative utilising Avoiding Unplanned Admissions enhanced service funding) for patients in the community, a Care Home Advanced Nurse Practitioner (ANP) and a Community ANP. The care home ANP worked to reduce unplanned hospital

admissions. This role was created 12 months ago and due to the success of the appointment the practice had utilised funding to make this role a full time position. We saw data from the practice that demonstrated the effectiveness of the care home ANP role. For example, in the first quarter of the project there had been 30 unplanned hospital admissions of which there had been 18 patients from care homes in the locality. This compared with the last quarter where there had been 17 unplanned hospital admissions and of these three were patients from care homes. Staff we spoke to from the care homes told us that they had very good working relationships with the nurse and the practice. They said they had provided professional care and support to help them provide the best care for their residents.

The community ANP role was to arrange phone calls and or visits to frail and elderly patients, including those who were recently discharged from hospital, to assess their needs and offer support. This service, introduced in April 2015 had provided patients with health assessment, medical care and support within their home.

The practice worked with the Worcestershire Alliance Board in partnership between Worcestershire Health and Care NHS Trust and South Worcestershire Healthcare as part of a Pro-Active Care Team (PACT). This team cared specifically for those patients who were on the unplanned admissions register with the aim to avoid further unplanned admissions to hospitals. Nationally reported data showed that the practice performed well against indicators relating to unplanned admissions. For the year ended March 2014 Pershore Medical Practice were 2% lower than the national average for admissions.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. The practice had engaged in a locality project with Age UK which involved referring patients for a home visit to assess their needs and inform them about additional support they could receive through a range of services and organisations (including the voluntary sector and charities as well as NHS organisations). Patients were given appropriate support to live as independently as possible. Nationally reported data showed that the practice performed well against indicators relating to the care of older people. The percentage of patients diagnosed with dementia whose care has been reviewed for the year 2014 to 2015 was 86% which compared with national rates of 83%. Practice data showed that of 108 patients with dementia on the practice register, medicine reviews had been carried out for 52% of these patients for this year so far.

The practice provided a range of services to meet the needs of patients with long term conditions. Three practice nurses were specifically trained in the management of diabetes care and this included a commitment to the Diabetic Expert Patient Programme which educated patients to manage their conditions. The practice was one of the highest performing practices in South Worcestershire for the care for diabetic patients. There was a high uptake of flu vaccines (99%) and foot examinations (93%) for diabetic patients.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some patients faced in accessing or using the service. For example, patients who misused drugs and alcohol were identified. The practice worked with a Shared Care service in conjunction with another practice, to engage with these patients in a positive way to help them towards recovery and eventual discharge.

Three female GPs worked at the practice and were able to support patients who preferred to see a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, although the practice building was on two levels, patients accessed the ground floor of the premises. Doors were wide enough for patients in wheelchairs to gain access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice offered open appointments for patients with hearing impairments as they recognised that patients may find it difficult to contact the practice by telephone. The practice also had a digital listener system available for patients to access. There was also an audiology service offered from the premises which worked in conjunction with the GP at the practice who specialised in ear, nose and throat (ENT) conditions.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients had a learning disability, or if a patient was also a carer so that additional appointment time could be made available. Where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available when needed. Staff told us that translation services were available for patients who did not have English as a first language. This service could be arranged to take place either by telephone or in person.

The practice was signed up to the learning disability direct enhanced service (DES) to provide annual health checks for their patients with a learning disability. The service looks to reduce the incidence of the presence of one or more additional disorders and premature deaths for people with learning disabilities. The DES is designed to encourage practices to identify patients aged 14 and over with the most complex needs and offer them an annual health check as well as a health action plan. As part of this service, the practice maintained a register of patients with learning disabilities. For the 2014 to 2015 year there were 28 patients on the register and an annual health check had been completed with all of them.

The practice also recognised they had a higher percentage of older patients registered with the practice. In order to ensure that patients' needs were being met, the practice was working on an innovative project which involved primary care working on a wider scale. For example, Pershore Medical Practice and two other local practices were working collaboratively with Age UK to develop a care team to provide support to patients who were over 85 years of age, who were not already on the unplanned admissions register or living in care homes.

The practice had a policy in place and provided equality and diversity training through e-learning. Clinical staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. We saw records that confirmed this training had been completed.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments, home visits and how to book appointments through the practice website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. There was an answerphone message which gave the telephone number patients should ring depending on their circumstances. Information about the out-of-hours service was provided to patients in leaflets, through information displayed in the waiting room and on the practice website. There was provision for patients with a hearing impairment at the practice. We saw signs within the waiting area to indicate a hearing loop was available; there was a screen which provided visual prompts for patients to be aware that they were being called for their appointment and staff told us that longer appointments would be made for patients with a hearing impairment.

The practice was open for appointments from 8am to 6.30pm Monday to Friday. The practice was closed at weekends but offered extended access appointments from 7.30am for three days per week and after 6.30pm on alternate Mondays, which was particularly useful to patients with work or study commitments. This was confirmed by two feedback comments received from patients who also told us that they found the online booking system and telephone consultations for patients helpful.

The practice operated an appointment system which increased the use of telephone contacts between the GP and the patient. This system had been used by the practice for many years and was well established long before the system was adopted into general practice. The practice told us they were a forward thinking practice and found this triage system had reduced the need for face to face consultations which freed appointment slots for those patients who needed them. The practice told us their aim was to ensure patients had prompt access to clinical staff.

Nurses in the practice treated patients for a wide range of common conditions. Patients could expect to see a nurse within one working day and the nurse practitioners the same day via triage. The nurse practitioners were qualified to prescribe from a range of medicines. Patients could book up to a month ahead for clinics at the practice.

Home visits were available for patients who were too ill to attend the practice for appointments. Longer appointments were also available for patients who needed them. This also included appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week, by a named GP or nurse.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients commented that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We found that there was an open and transparent approach towards complaints. Accessible information was provided to help patients understand the complaints system on the practice's website and in a complaints leaflet available at the practice. We saw that there was also an easy read information sheet and template made available for patients who had a learning disability.

Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. None of these patients had ever needed to make a complaint about the practice. Staff told us that they were aware of what action they would take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans in place to address changes needed. We saw minutes that confirmed these discussions had taken place.

We saw that the practice had recorded all complaints, including verbal and written complaints. All details were logged on a spreadsheet so that progress in responding to all complaints could be monitored. Annual audits of complaints had been carried out to identify themes or trends.

We tracked four complaints and found these had been handled in accordance with their policy, in a timely way with learning identified where appropriate. For example, we saw complaints had been made by patients about the telephone system, phone calls from doctors, x-ray results and blood test appointments. We saw that action had been taken in response to these complaints. This included for example, an investigation into the telephone system and a calls analysis carried out during November 2014, for which a report was produced on the findings. Written explanations had been sent to patients in response to their complaints. In response to one complaint an explanation about the way calls into the surgery were handled had been provided by the practice. For another complaint the practice had clarified the blood test appointment system. We saw evidence that the practice had responded to the patient's concerns appropriately and in line with their procedures, and where appropriate an apology had been made.

The practice reviewed the complaints received for each year and these were shared with all staff in a presentation format. For example, the review for the year 2014 identified that the practice had received 11 written complaints and they had been responded to in writing. There had been 32 verbal complaints which they had responded to either verbally on the same day or by letter. We saw that the complaints varied and had not identified any particular themes or trends. We saw evidence that lessons learned from individual complaints had been acted on and included further training needs where they had been identified. The annual review shared overall learning from the complaints with all staff members to ensure that learning continued to be shared and reviewed in an open and responsive way.

We saw that compliments received by the practice had been kept. Examples of some of the compliments received included thanks for the treatment and care the practice had provided to families, thanks to all the practice staff who were considered by patients to be friendly and prepared to listen to patients' concerns.

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 sent us a copy of their statement of purpose prior to the inspection of the service. This told us that the aim of the practice was to provide high quality, cost effective care to patients registered with them by offering both core and enhanced services. The practice aimed to provide general medical services to all registered and temporarily registered patients, including appropriate diagnosis and treatment, timely referrals into specialist services and the active care of patients with long term conditions. The practice also aimed to provide immediate necessary treatment to any patient, registered or not, who presented at the practice as an emergency.

The practice's vision was to develop a traditional general practice in a modern way that enabled them to provide the best care for all their patients. They aimed to achieve this using their knowledge, expertise, experience, high quality care record and positive engagement with the local health economy. Staff we spoke with were aware of this vision and showed a strong commitment to work to provide this level of service for all patients.

The practice carried out proactive succession planning. We saw details of the latest plan which showed consideration for the future retirement of staff. The practice acknowledged the need to ensure replacement staff would be available and trained to enable a smooth transition and ensure continuity of care for patients. There was evidence that this process had been started with the recent recruitment of nursing staff. Staff told us they were supported to train and develop beyond their roles and move into positions with greater responsibilities. There was positive and constructive engagement with staff and a high level of staff satisfaction.

There were positive examples of how the practice's vision and ethos were implemented by the staff team working together to maintain high standards, deliver positive health outcomes for patients and foster a supportive work environment. We saw examples of how the staff team worked together and supported each other throughout the inspection. Quality performance data showed the practice was performing exceptionally high compared with local and national averages, achieving an overall score of 99.1% in the 2014 to 2015 year.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer desktop within the practice. We looked at 11of these policies and all 11 policies and procedures had been reviewed annually and were up to date.

There was a clear leadership structure and all clinical members of staff had lead roles and specific areas of interest and expertise. For example, there were leads for infection control, minor surgery, safeguarding, learning disability, dementia and prescribing. They were engaged with the wider local medical community and attended Clinical Commissioning Group (CCG) meetings and some were actively involved in the Local Medical Committee. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There were systems in place to monitor and improve quality and identify risk. Staff had received inductions, regular performance reviews and attended staff meetings and events. A presentation was given to all the staff each year to share with them the reviews that had taken place for all the complaints, significant events and incidents that had occurred throughout the year. The practice reviewed the learning that had taken place and changes made to practise to ensure these had been maintained.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a national performance measurement tool. The QOF data for this practice showed that in all relevant services it was performing above the national standards. We saw that QOF data was regularly discussed at weekly meetings and action taken to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a respiratory audit of patients who used inhalers for breathing conditions carried out in April 2014 found that the practice had not reviewed patients for inhaler use. A re-audit had been carried out for the period November 2014 to March 2015 and showed that 128 patients had been reviewed following the initial audit. The practice had arrangements

Are services well-led?

Good

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

in place for identifying, recording and managing risks. We saw evidence where risk assessments had been carried out which identified key risks, with action plans in place to manage and minimise these risks. Risks included those associated with fire, manual handling and lone workers. The practice held regular governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed and actions had been taken to address any required improvements.

Leadership, openness and transparency

At the start of the inspection we were given a presentation on the services provided by the practice by representatives from all teams within the practice. They told us about the structure of the practice. The GPs were a team of equals who shared the role of chair- partner on a rotational basis. They believed strongly that this equality created a healthy, open management environment that filtered throughout the whole organisation. We observed how everyone interacted and supported each other during the practice presentation and this continued throughout the day. The atmosphere was friendly, open, supportive and welcoming.

There was a clear, visible leadership and management structure in place with responsibility for different areas shared amongst GP partners. For example, all the partners had various lead responsibilities such as safeguarding, palliative care, business and the premises leads. Clinical staff also had lead roles such as the lead nurse for infection control. We spoke with six members of staff and they were all clear about their own roles and responsibilities.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and that the GP partners were visible and accessible. Staff were positive about working at the practice which they described as patient focussed. They told us the team were close and supportive and everyone was included. They said they felt valued and that it was a great team with good teamwork. Clinical staff commented that there was also a low turnover of staff in the nursing team and they had developed close and supportive working relationships. A recently recruited member of the staff team told us they had been well supported when they joined the practice and made to feel very welcome by everyone. Staff said they could approach the GPs and management team and one person gave us an example of asking a GP for advice about a patient earlier that day. GPs also confirmed that there was an open and transparent culture of leadership and encouragement of team working. GPs we spoke with told us that team work at the practice was one of their greatest strengths.

We found the practice to be open and transparent and prepared to learn from incidents and near misses. Weekly practice meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff.

We saw the system in place for the dissemination of patient safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on all patient alerts and kept a record of the action they had taken where this was applicable.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy and bullying and harassment which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

Pershore Medical Practice was committed to continually improve their services by learning from and listening to their patients. The practice had a virtual Patient Participation Group which was formed in 2011. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

An active PPG was established 18 months ago and were drawn from members of the virtual PPG to run in conjunction with the virtual PPG which had been established for many years. We saw minutes of meetings where the group had met and discussed a range of topics. There was a dedicated page on the practice website for the group, as well as a direct email address for patient feedback. Minutes of the meetings, PPG reports and patient survey results were made available on the practice website. Copies were also made available to patients at the practice reception.

We looked at the recent meetings and reports of the PPG. During 2014 members of the PPG and practice staff had reviewed and acted on a variety of feedback sources from patients. This included the survey carried out in February 2014, patient complaints, verbal feedback gathered by PPG

Are services well-led?

Good

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

members, and feedback from the NHS Friends and Family test. Key priorities had been identified and an action plan had been developed. The PPG had identified access, care for patients returning home from hospital and improvements in communication with patients as the key priorities for the practice.

We saw from the action plan that online booking had been activated for some nurse appointments. Six nurse appointments a day had been made available and the number of appointments which patients could book with GPs on-line had also been increased. The report told us that the practice had worked with the Alliance Board which comprised of Worcestershire Health and Care Trust and South Worcestershire Healthcare to appoint and support two new roles for patients in the community, a Care Home Advanced Nurse Practitioner (ANP) and Community ANP. Their role was to review discharge summaries and arrange phone calls and/or visits to patients who were recently discharged from hospital, to assess their needs and offer support. The practice were also engaged in a locality project with Age UK which involved referring patients for a home visit to assess their needs and inform them about additional support they could receive through a range of services and organisations (including the voluntary sector and charities as well as NHS organisations).

The practice had also made improvements in the ways in which they communicated with patients. This included the production of a monthly newsletter and more pro-active use of the screens in the waiting areas to improve information sharing with patients. Quarterly Newsletters were produced and distributed through the practice website and in practice waiting areas. We saw a copy of the latest newsletter for Spring 2015. The newsletter included information about opening times, how to order prescriptions online, as well as practice news, PPG news and practice updates.

The practice had gathered feedback from staff through informal staff meetings and discussions. Staff confirmed this. Minutes from meetings were kept and we were able to see evidence of a recent meeting between the practice manager and the GPs. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Recently employed staff told us they had been made welcome when they joined the practice and supported with their learning of the procedures. They confirmed that they worked well together as a team and it felt more like being in a family than working with colleagues. However, if they had any concerns they confirmed that they would follow the whistleblowing policy which was available to all staff on their computers in the practice which gave them guidance to follow. Staff confirmed that they knew who to talk with in the event they had any concerns.

Management lead through learning and improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events (SEs), complaints and palliative care for patients, with actions to be completed where appropriate.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, SEs and complaints were appropriately logged, investigated and actioned. For example, we saw that SE reporting had been discussed at the practice meeting held on 16 March 2015.

Staff told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. Staff told us that the practice was very supportive with training and that regular protected time was provided for learning. Staff told us that information and learning was shared with all staff at practice meetings.

We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. We saw examples of staff progression within the practice through development and training opportunities. We spoke with staff who told us they had been encouraged to develop their skills in ways they may not have previously considered because their skills and abilities had been recognised by the practice.

The practice manager showed us the review presentation that was shared with all staff annually. The practice manager told us this ensured learning had taken place, that all incidents and complaints had been reviewed and

Are services well-led?

Good

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

that changes made to practice had been maintained. Staff we spoke with confirmed that these sessions were held annually and that they felt involved and included in these reviews.