

Malvern Health Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Malvern Health Centre on 19 January 2016. Overall the practice is rated as good.

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

- There were systems in place to mitigate safety risks including analysing significant events and safeguarding. The premises were clean and tidy. Systems were in place to ensure vaccines stored appropriately and in date.
- Recruitment procedures included all relevant checks to protect patients from harm. Systems were in place for safe hygiene practices by staff to protect patients from unnecessary risk of infections.
- Patients had their needs assessed in line with current guidance and clinical staff had a holistic approach to patient care. Staff promoted health education to empower patients to live healthier lives.

- Feedback from patients and observations throughout our inspection showed that staff were kind, caring and helpful. They told us they were satisfied with the standards of care.
- Practice staff worked closely with other organisations and external professionals in planning how services were provided to ensure that they meet people's needs. People with complex needs had care plans in place that were regularly reviewed.
- Complaints were dealt with appropriately and honest feedback was provided to the complainant.
- Staff worked together as a team. There was a clear leadership structure and staff felt supported by management. It was evident that there was a motivated staff team.

However, there was an area of practice where the provider needs to make improvements.

The provider must:

Summary of findings

- Review the clinical audit programme to ensure continuous improvements are made to patient care. Ensure that audits are dated and include a timescale for when they will be re-audited to ensure improvements made in patient care have been sustained.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to staff in supporting improvement. Information about safety was recorded, monitored, addressed and actions taken were monitored. Risks to patients were assessed, well managed communicated widely enough to support improvement. There was a recruitment policy and procedure in place to ensure patients safety was protected. There were enough staff to keep people safe.

Good



Are services effective?

The practice is rated requires improvement for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and they told us they used it routinely. Staff worked with other health care teams and there were systems in place to ensure appropriate information was shared. Staff had received training appropriate to their roles. There was evidence of appraisals and personal development plans for all staff. Arrangements were in place to review and monitor patients with long term conditions and those in high risk groups.

There was evidence that clinical audits did not always include the date they had been carried out, improvements that had been made or the date for when they would be repeated. This indicated that clinical audits were not always being used adequately to drive improvements in patient care.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. There was supporting information available to help patients understand and access the local services available. We also saw that staff treated patients with kindness and respect and their confidentiality and privacy were maintained. The National GP Patient Survey results from July 2015 showed that higher numbers of patients were involved with developing their care plans compared to local and national averages.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated good for providing responsive services. It reviewed the needs of its local population and engaged with the local Clinical Commissioning Group (CCG) to provide improvements to services where possible. Services were planned and delivered to take into account the needs of different patient groups. The practice had good facilities and was well equipped to assess and treat patients in meeting their needs. Information about how to complain was available in the practice leaflet and records showed that senior staff responded appropriately and promptly to issues raised. Learning from the outcomes of complaints was shared with staff.

Good



Are services well-led?

The practice is rated good for being well-led. It had a clear vision and strategy. Governance arrangements were underpinned by a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risks. Practice staff encouraged feedback from staff and patients, which it acted on. There was a proactive Patient Participation Group (PPG) who represented patients by influencing improvements. Newly appointed staff underwent inductions and training to enable them to carry out their roles effectively. Regular performance reviews were carried out and staff attended training courses, meetings and events to improve their skills.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated good for the care of older people. The practice offered personalised care to meet the needs of the older people in its population and home visits were carried out all clinical staff to those who were unable to access the practice. Rapid access appointments were provided for those with enhanced or complex needs. The practice had regular contact with district nurses and other professionals in meetings to discuss any concerns or changes that were needed to patient care. Older patients were offered annual health checks and where necessary, care, treatment and support arrangements were implemented.

Good



People with long term conditions

The practice is rated good for people with long term conditions. Practice nurses and GPs were involved in the management of patients with chronic diseases and those at risk of hospital admission. All of these patients had regular health reviews with either the GP and/or the nurse to check their health and medication. Patients with complex needs had care plans in place and these were reviewed regularly. Patients were able to carry out self-blood pressure monitoring at home. They were also provided with anti-coagulation monitoring in their own home if they could not access the practice.

Good



Families, children and young people

The practice is rated good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. A health visitor was invited to the regular multidisciplinary meetings to discuss any safeguarding issues as well as those children who had long term conditions. There were extended opening hours with appointments starting at 7.40am each day. Appointments were also available from 9am until 12pm one in every four Saturdays. Patients could hold a telephone conversation with a GP to receive advice. Children were given same day appointments and there was emphasis on children receiving their required vaccinations.

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group. GPs liaised with and sought advice from other health and social care professionals to promote provision of appropriate care. Extended hours were provided to assist patient's ability to attend the practice outside of working hours.

People whose circumstances may make them vulnerable

The practice is rated good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Clinical staff carried out annual health checks for patients with a learning disability and longer appointments. Staff knew how to recognise signs of abuse, they kept a register and the computer system included alerts of those patients who were considered to be at risk. Staff were aware of their responsibilities regarding the actions they should take if they had concerns and we saw evidence of this.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated good for the care of people experiencing poor mental health (including people with dementia). Staff were trained to recognise mental health presentations and carry out comprehensive assessments. Practice staff regularly worked with multidisciplinary teams in the case management of patients who experienced poor mental health. Patients who had dementia were included in these meetings and the minutes we saw evidenced this. Clinical staff carried out care planning for patients with dementia and those experiencing mental health illness. Referral mechanisms were in place for when staff identified deterioration in patient's mental health.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing the same as or above local and national averages. There were 108 responses, this equated to 42% of the questionnaires that had been sent out.

- 95% of respondents found the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 73% of respondents usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 67% and a national average of 65%.
- 60% of respondents felt they did not normally have to wait too long to be seen compared with a CCG average of 60% and a national average of 58%.
- 90% of respondents said last time they spoke with a GP they were good at giving them enough time compared with a CCG average of 90% and a national average of 87%.

- 78% of respondents found it easy to get through to this surgery by phone compared with a CCG average of 76% and a national average of 73%.

During our inspection we spoke with 10 patients. All patients told us they were satisfied with the service they received. One patient commented that it was sometimes difficult to get an appointment when they wanted one. All patients spoken with told us they were satisfied with the standards of care they received. Some used words such as; 'fantastic and brilliant' to describe their care. As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards. There were no negative comments about their ability to get an appointment. All said they were happy with the care they received. Some comments were included details about high standards of care. During our inspection we spoke with two members of the Patient Participation Group (PPG) who told us they felt that they received good care. PPG's are a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Areas for improvement

Action the service MUST take to improve

- Review the clinical audit programme to ensure continuous improvements are made to patient care.

Ensure that audits are dated and include a timescale for when they will be re-audited to ensure improvements made in patient care have been sustained.

Malvern Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, specialist advisor.

Background to Malvern Health Centre

Malvern Health Centre serves approximately 9,850 patients. The practice holds a General Medical Services contract - a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice is managed by five GP partners (three male, two female) and there are four salaried GPs who between them provide 58 clinical sessions per week. They are supported by two nurse practitioners who between them work 45 hours per week. There are four practice nurses and three health care assistants (HCA) who work varying hours. Clinical staff specialise in specific areas such as; diabetes, end of life care, dementia, infection control, cervical screening and anti-coagulation. Nursing staff and HCAs also provide healthy living advice and phlebotomy services. The practice manager has responsibility for a deputy practice manager, 13 receptionists/administrators, two medical secretaries, an administrator and a finance manager.

The practice is a designated training practice for trainee GPs. These are qualified doctors (registrar) who are learning the role of a GP. There is also a physician's assistant working at the practice to gain work experience and for training purposes. They are supervised at all times when prescribing.

The practice provided enhanced services such as; minor surgery and an early appointment systems (extended hours).

The practice is open from 7.30am until 6.30pm each day and between 8.30am and 12pm one in every four Saturdays. Appointments are available from 7.40am until late morning each weekday and from 9am until 12pm one in every four Saturdays. Urgent appointments are available on the day and extra are available if needed. Routine appointments can be pre-booked in advance in person, by telephone or online. Telephone advice is also available for patients who are unsure if they need an appointment and for provision of advice for children.

The practice has opted out of providing GP services to patients out of hours such as nights and weekends. During these times GP services are provided currently by a service commissioned by South Worcestershire Clinical Commissioning Group (CCG). When the practice is closed, there is a recorded message giving out of hours' details. This information is also on display throughout the practice.

Why we carried out this inspection

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

Detailed findings

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 January 2016. During our visit we spoke with a range of staff including three GP partners and one salaried GP, a nurse practitioner, a practice nurse and a HCA. Non-clinical staff included the practice manager, the deputy practice manager, three receptionists/administrators and a medical secretary. We spoke with 10 patients who used the service and two members of the Patient Participation Group (PPG). We observed how people were being cared for and talked with family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

Safety was a priority and staff used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

Practice staff carried out an analysis of all significant events. We viewed the significant events for the previous 12 months and found evidence that all events had been recorded, investigated, discussed with relevant staff and any learning from them clearly documented and shared. For example, switching the power supply off to a vaccine fridge. Advice was sought from the vaccine manufacturer to minimise risks to patients, an investigation was carried out and systems were put in place to prevent a similar recurrence.

Safety was a regular agenda item during the GP partner meetings that were held every two weeks. Where common themes were identified changes were made in order to address them. Outcomes were disseminated to all relevant staff to ensure that lessons learnt were actioned appropriately.

National patient safety alerts were disseminated to staff and where necessary actions were taken to promote patient safety.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The policies were appropriate and accessible to all staff. They included contact details of external professionals if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding who had been trained to an appropriate level. The GPs attended safeguarding meetings when possible and provided reports for other agencies. Clinical staff kept a register of all patients that they considered to be at risk and regularly reviewed it. We saw evidence of a recent referral that had been made to

the authority who were responsible for carrying out investigations. This indicated that staff took appropriate action when necessary. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.

- A notice was displayed in each consulting room and in the practice leaflet, advising patients of their right to have a chaperone. All staff who acted as chaperones were trained for the role and had undergone a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Some patients we spoke with were aware that they could request a chaperone. Staff we spoke with demonstrated that they had good knowledge about the role of chaperoning.
- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, clinical waste and legionella. Legionella is a term used for particular bacteria which can contaminate water systems in buildings.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be visibly clean and tidy. A practice nurse was the infection control clinical lead and they were assisted by a HCA. They attended relevant training course to improve their knowledge and skills and to keep up to date with best practice. All staff had received infection control training. We were shown a report dated 14 January 2016 concerning an infection control audit that had been carried out by specialist staff by a local hospital late the previous year. The overall result was positive and there were three areas that needed addressing. They included, minor plaster damage to the walls, the layout of the room where minor surgery was carried out and a

Are services safe?

flushing programme for unused water taps but these were rated as low risk of harm to patients. Practice staff told us they had not had opportunity to create an action plan to address them but that they would.

- Recruitment checks were carried out and we were shown these for all staff. They showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. There was staff induction programmes and these were tailored to the staff roles. Newly recruited staff were supervised until senior staff assessed that they were safe to work independently.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There had been a change in the practice boundary and this had resulted in a reduction of the number of patients registered at the practice. There were restrictions on the numbers of staff who could take annual leave at the same time. All staff absences were covered by other staff working extra shifts and patients' appointments were arranged accordingly. We were told that the salaried GPs carried out extra sessions when partners were on annual leave and if necessary locum cover was provided by a restricted number of GPs who were familiar with the practice. Appropriate checks of locum GPs had been carried out.

- We checked that medicines were securely stored at the practice and only accessible by authorised staff. Checks were made on the expiry dates of all medicines and those we checked were within their expiry dates. The fridge temperatures were recorded where vaccines were stored and expiry dates had been checked. When the lead for this was on annual leave another staff member took on the responsibility.

Arrangements to deal with emergencies and major incidents

All staff received regular basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen. There was a formal medical emergency protocol in place and when we discussed medical emergencies with staff, they were aware of what to do. Clinical staff had developed written guidance for staff to follow in the event of different types of emergencies. For example, a child who had acute shortness of breath, epileptic seizure and collapse.

There was a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this was held off site to ensure that appropriate response would be instigated in the event of eventualities such as loss of computer and essential utilities.

Regular fire drills were carried out so that staff could respond promptly and appropriately in the event of a fire.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, they had a full health check which included information about the patient's individual lifestyle, their medical conditions and any prescribed medicines. They were given information about the services available to them to make best use of the practice.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, for those with a learning disability and palliative care register.

The practice took part in the avoiding unplanned admissions scheme. Patients were seen by a GP within three days of discharge. They also participated in the end of life (EOL) and frailty schemes. Assessments were carried out on those patients who were displaying symptoms of dementia to promote early diagnosis and treatment. Clinicians identified and reviewed their individual patients and discussed patient needs at two weekly clinical meetings to ensure care plans were in place and regularly reviewed.

Two nurses and a GP specialised in diabetes. A diabetic nurse consultant from the local hospital visited the practice once a month and assisted with sessions where patients who had complex diabetes needs were seen. This ensured that staff had up to date knowledge and skills and that patients received assessments and treatment that met their needs.

Nurse prescribers, practice nurses and the HCAs assisted GPs in carrying out home visits to patients who were unable to access the practice. They administered vaccinations, carried out health checks and reviews of patients with long term conditions. One HCA did anti-coagulant assessments in the patient's home. They entered the test results into the practice computer and

telephoned the patient to advise them of the correct warfarin dosage. Patients who experienced mental health problems were given double appointments and follow-ups to monitor their condition.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recently published results dated 2014-15 showed;

- The dementia review rate of 100% was 1.2% above the CCG and 5.5% above the national average. The practice exception rate was 3.1%.
- The mental health review rate of 100% was 5.3% above the CCG average and 7.2% above the national average. The practice exception rate was 2.9%.
- Performance for asthma related indicators was 100% which was 1.5% above the CCG average and 2.6% above the national average. The practice exception rate was 10.2%.
- Performance for patients with a learning disability was 100% which was the same as the CCG average and 0.2% above the national average. There was no exception rate for this disorder.
- Performance for diabetes related indicators was 94.2% which was 0.4% above the CCG average and 5.0% above the national average.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators were 100% which was 1.9% above the CCG average and 4.0% above the national average. The practice exception rate was 10.9%.
- The percentage of patients with hypertension having regular blood pressure checks was 100% which was 1.7% above the CCG average and 2.0% above the national average. The practice exception rate was 0.2%.

The practice had an overall exception reporting of 9.0%, which was 0.7% higher than the local Clinical Commissioning Group (CCG) average and 0.2% less the

Are services effective?

(for example, treatment is effective)

national average. Exception reporting is the exclusion of patients from the list who meet specific criteria. For example, patients who choose not to engage in screening processes.

We were shown six examples of clinical audits that had been carried out by GPs. Three concerned referral statistics, were not dated and did not include whether any actions were needed. Three other audits concerned prescribed medicines for specific conditions. Two were not dated and two did not indicate if they would be repeated to check if changes made in patient care had been sustained. This system did not fully ensure clinical risks to patients were identified, assessed and minimised through clinical audits.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. Staff received training that included safeguarding vulnerable children and adults, basic life support and information governance awareness. There was a training schedule in place to demonstrate that staff had repeated courses to ensure they had up to date knowledge and skills. The practice was closed for half a day each quarter to accommodate training that was organised by senior staff and group discussions about staff practices. Emergency cover for home visits and appointments was provided by another GP during these staff training days.

All GPs were up to date with their yearly continuing professional development requirements and they had been or were in the process of being revalidated. (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). There was an annual appraisal system in place to ensure that all members of staff had formal appraisals.

Coordinating patient care and information sharing

Staff had information they needed to deliver effective care and treatment to patients who used services and put systems in place to capture medication review dates. Staff were able to access all the information they needed to plan and deliver care and treatment in a timely and accessible

way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records, hospital information and test results.

We saw evidence that multi-disciplinary team meetings took place regularly and that care plans were routinely reviewed and updated. Practice staff and external professionals shared relevant information about patients who had complex needs or were receiving palliative (end of life) care to ensure they delivered seamless patient care. This included when people moved between services, including when they were referred, or after they were discharged from hospital.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. When consent was obtained it was recorded in the patient's medical records in line with legislation and relevant national guidance.

All clinical staff knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. Staff understood the key parts of legislation of the Children's and Families Act 2014. GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment). Two patients we spoke with described how a GP spoke with their child in an appropriate way.

Health promotion and prevention

All of the patients who had attended the practice had received advice about smoking cessation and/or weight reduction. This service was provided by nurses and HCAs.

To assist with the care of those patients who had complex needs Diabetes in the Community Care Extension (DiCE) monthly sessions were introduced at the practice. A consultant who specialised in diabetes holds clinics at the practice to work with staff and see patients and plan their care needs.

Are services effective?

(for example, treatment is effective)

All patients who had attended the practice and were eligible for contraceptive advice had received it. The uptake for cervical screening was 95%, this was 3.6% below the CCG average and 2.6% below the national average.

The practice offered childhood flu vaccinations during the Saturday morning sessions. The uptake up to the end of November 2015 was two year olds 51.6%, three year olds 56.6% and four year olds 41% had been immunised.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given pre-school age were 95% and 91.1% had completed the course during 2014-25.

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

Patients who had complex needs or had been identified as requiring extra time were given longer appointments to ensure they were fully assessed and received appropriate treatment. Patients who were experiencing mental health problems were given double appointments to ensure that all of their health needs were assessed and treated.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that all staff were courteous and very helpful to patients both in person or on the telephone and that people were treated with dignity and respect. Curtains were used in consulting rooms to protect patient's privacy and dignity during examinations. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard outside of them. Reception staff told us that they would invite patients to move to an unoccupied room when patients needed to discuss sensitive issues or personal issues.

All of the 22 patient CQC comment cards we received were positive about the service they experienced. The 10 patients we spoke with said they felt the practice offered a good service. We received comments which described that patients were very satisfied with their care. They all commented that staff were helpful and caring towards them. We spoke with two members of the Patient Participation Group (PPG) on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy were always respected.

Results from the national GP patient survey from July 2015 showed patients opinions about the service they received. The results were above and below average for patient satisfaction. For example:

- 89% of patients said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 88% of patients said the last GP they saw or spoke with was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.

- 99% of patients said the last nurse they spoke with or saw was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.
- 98% of patients said they had confidence and trust in the last nurse they saw or spoke with compared to the CCG average of 97% and national average of 97%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us they felt involved in decision making about the care and treatment they received. They also said they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choices of treatments available to them. The information in the comment cards was aligned to these views.

The results for the national GP survey showed that patients responses were in line with the local CCG and national averages:

- 87% of patients said the last GP they saw or spoke with were good at explaining tests and treatment compared to the CCG average of 90% and national average of 86%.
- 87% of patients said the last GP they saw or spoke with was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 81%.
- 93% of patients said the last nurse they saw or spoke with was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

Clinical staff regularly reviewed and planned care in conjunction with external professionals to ensure patients received appropriate and up to date care.

Staff told us that translation services were available for patients who did not have English as their first language but they had not needed to use it.

Patient/carer support to cope emotionally with care and treatment

Notices in the waiting area and leaflets told patients how to access a number of support groups and organisations.

Are services caring?

The practice's computer system alerted clinical staff if a patient was also a carer. Written information was available within the practice and on the website that directed carers to the various avenues of support available to them.

Staff told us that if families suffered bereavement, the respective GP contacted them by phone. This call was either followed up by a patient consultation and/or advice on how to find a support group.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an established patient participation group Patient Participation Group (PPG). PPG's are a group of patients registered with a practice who work with the practice to improve services and the quality of care. Adverts encouraging patients to join the PPG were available on the practice's website. The PPG met quarterly and patient surveys were sent out annually. We spoke with two members of the group who told us the practice had been responsive to their concerns. For example, replacement of chairs with ones that could be wiped clean.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements. For example the practice had signed up to a CCG initiative to reduce the numbers of unplanned admissions. All patients who had been admitted were assessed by a GP after their discharge from hospital and care plans put in place to prevent unnecessary admissions.

The practice received at least three visits per annum by South Worcestershire Clinical Commissioning Group (SWCCG). The purpose of these were to monitor the quality of patient care. We were shown the agenda items and minutes from the meeting held on 7 December 2015. They included dementia, asthma, heart failure, other conditions, prescribing and exception rating. The minutes included actions that should be taken to promote appropriate patient care.

Services were planned and delivered to take into account the needs of different patient groups and provide flexibility, choice and continuity of care. For example,

- Telephone advice was provided for patients who could not attend during normal opening hours.
- There were longer appointments available for people with complex needs.

- Home visits were available by all clinical staff for elderly patients and those who were unable to access the practice. This included the anti-coagulation service for patients.
- Urgent access appointments were available for children and those with serious or complex medical conditions.
- On the day requested appointments were always accommodated regardless of the fact that the session lists were full.

Access to the service

The practice was open from 7.30am until 6.30pm each day and between 8.30am and 12pm one in every four Saturdays. Appointments were available from 7.40am until late morning each weekday and from 9am until 12pm one in every four Saturdays. Urgent appointments were available on the day and extra were provided even if the sessions were fully booked. Routine appointments could be pre-booked in advance in person, by telephone or online. Telephone consultations were available for patients who were unsure if they need an appointment and for provision of advice for children's health.

With the exception of one patient we spoke with on the day of the inspection they told us they were satisfied with access and that they would always be seen urgently. All of the 22 comment cards we received provided positive information about access to the practice.

The deputy practice manager proactively managed the appointment system on a daily basis. It was adapted in response to varying workloads. We spoke with a receptionist who told us that if all sessions were fully booked they informed the deputy practice manager who released an extra appointment. This indicated that all patients who felt they needed to be seen on the day were accommodated.

Results from the national GP patient survey July 2015 showed that patients' satisfaction with how they could access care and treatment were in line with the local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example,

- 78% of patients said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.

Are services responsive to people's needs?

(for example, to feedback?)

- 72% of patients described their experience of making an appointment as positive compared to the CCG average of 78% and national average of 73%.
- 74% of patients reported they were satisfied with the opening hours compared to the CCG average of 77% and national average of 75%.

As a result of the last patient survey and comments made by the PPG senior staff had reviewed the telephone system. The practice manager told that a new improved system had been ordered to improve patient access.

There was a mixture of male and female GPs to enable patients to make choices about who they wished to be seen by.

The practice was carrying out a pilot with the objective of increasing patient access to the same GP. One GP was making the next patient appointment with them during the consultation. The practice had not had opportunity to review the result of the pilot, which was on-going.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

Information about how to make a complaint was available on the practice's website and in the reception. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

The practice kept a complaints log and we reviewed the complaints received over the past 12 months. We noted that they had been dealt with appropriately and actions taken where necessary for staff to make changes to prevent a similar recurrence.

Are services well-led?

Good 

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

Our findings

Vision and strategy

Senior staff had a clear vision to deliver high quality care and promote good outcomes for patients. There was a mission statement for the promotion and delivery of an effective service of the highest possible standard.

Various issues were being reviewed, for example:

- Staff succession planning.
- Senior staff were checking that methods of working were the most efficient and making changes where necessary.
- The appointments system was being reviewed daily to assist senior staff in providing the most effective system.
- Discussions were taking place to change the practice boundary. If successful there would be an increase in the number of registered patient.

Partners planning meetings were held every six months to plan the future operations of the practice. For example, requesting a pharmacist to review the prescribed medicines of patients who experienced mental health illness and workforce planning.

Governance arrangements

There were policies and procedures to support governance arrangements, which were available to all staff on the practice computer. Newly recruited staff were given a handbook about how the practice operated and some of the policies.

Clinical staff used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data showed that the practice was performing in line with national standards. Results were discussed regularly during meetings.

Practice meetings were held every two weeks where standards of clinical care were discussed. Partner meetings were held every two weeks where the day to day operations of the practice were discussed.

Clinical staff had an understanding of the performance of the practice and were aware of the plans to make improvements. There were clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.

Leadership, openness and transparency

Staff had specific lead roles within the practice for example safeguarding and infection control for effective day to day running of the practice.

The partners and the practice manager had the experience, capacity and capability to run the practice effectively and identify where improvements were needed. They prioritised safe and high quality patient care. The partners were visible in the practice and staff told us that they were approachable and they felt well supported. The partners encouraged a culture of openness and honesty.

Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and report concerns. Staff said they felt respected and valued by senior staff. Partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

There was a patient participation group (PPG) in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with two members of the PPG who told us they felt that the practice was responsive to any issues raised by the group. For example, the television screen in the waiting area informed patients if a GP was running behind with their appointments. They told us that practice staff were very patient centred and had involved them in any proposed changes to the service.

The practice was in the process of conducting a staff survey to obtain the views of staff about how the practice worked. Staff we spoke with displayed motivation to make changes and told us there was a strong team and every staff member was approachable. There was evidence that clinical and non-clinical staff had learnt from some incidents and complaints and improvements made were discussed during meetings.

The practice was participating in the 'Friends and Family' survey where patients were asked to record if they would recommend the practice to others. The survey commenced December 2014 and the practice manager submitted monthly reports to the local CCG. We looked at the results for December 2015. There were 12 responses and all said they would recommend the practice to others.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>This is a breach of Regulation 17(2)f of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, evaluate and improve practice in respect of assessing, monitoring and mitigating risks relating to the health, safety and welfare of patients.</p> <p>The provider must review the clinical audit programme to ensure continuous improvements are made to patient care. Ensure that audits are dated and include a timescale for when they will be re-audited to ensure improvements made in patient care have been sustained.</p>