

# Barbourne Health Centre

## Quality Report

44 Droitwich Rd,  
Worcester, WR3 7LH  
Tel: 01905 22188  
Website: [barbournehealthcentre.nhs.uk](http://barbournehealthcentre.nhs.uk)

Date of inspection visit: 22 April 2015  
Date of publication: 02/07/2015

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

## Ratings

### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8
Areas for improvement	8

### Detailed findings from this inspection

Our inspection team	10
Background to Barbourne Health Centre	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Barbourne Health Centre on 22 April 2015. We have rated this practice overall as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Patients were kept safe. There were arrangements in place for staff to report and learn from key safety risks. The practice had a system for reporting, recording and monitoring significant events over time.

- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Opportunities for learning from internal and external incidents were taken.
- The practice was clean and hygienic and had robust arrangements for reducing the risks from healthcare associated infections.
- 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.
- 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.

However, there were also areas of practice where the provider should make improvements. The provider should:

# Summary of findings

- Risk assessments should be carried out to determine whether identity details should be obtained for staff employed by the practice before it was registered with the Care Quality Commission (CQC).

**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 report incidents and near misses. We saw evidence of procedures having been changed as a result. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and any safety issues addressed. The practice assessed risks to patients and managed these well. There were enough staff to keep people safe and the practice had recently recruited additional clinical and administrative staff to fill vacancies created when staff had left the practice during the last 12 months.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at an average level for the locality. Patients' care and treatment took account of guidelines issued by the National Institute for Health and Care Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions. The practice had recently made organisational changes to allow GPs to have more time to focus on patients with long term conditions. GPs also regularly audited areas of clinical practice and we saw how the clinical audit process had recently been improved. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Good



### Are services caring?

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Patients also told us they felt the practice had improved after going through a difficult time with staffing last year. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement.

Good



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and

Good



# Summary of findings

engaged with the NHS England Area Team (NHSE) and South Worcestershire Clinical Commissioning Group (CCG) to secure service improvements where these were identified. At the time of our inspection, NHSE and the CCG were monitoring the practice following concerns in the practice's performance since the beginning of 2015. These concerns covered organisational issues and the practice's performance against its targets under the Quality and Outcomes Framework. This is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. Patients we spoke with during our inspection reported good access to the practice and said that urgent appointments were available on the same day. The practice was well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

## Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy which had been recently re-focussed following changes within the GP and staff team. Staff, including those recently employed by the practice, were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and plans were in place to appoint additional GP partners. Staff felt supported by management and felt confident that the practice had improved within recent months and could now move forward after the changes that had occurred within the last 12 months. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP. When appropriate, they were included on the practice's avoiding unplanned hospital admissions list. The practice also reviewed hospital discharge records on a daily basis. This alerted the team to patients who may be more vulnerable. Flu and pneumonia vaccinations were carried out. If patients were unable to travel to the practice, GPs and an advanced nurse practitioner carried out visits to their homes. Care plans were also in place for the most vulnerable patients, including those within the local care home served by the practice. GPs also carried out regular 'rounds' and medicines reviews within the care home. GPs and advanced nurse practitioners carried out visits to patients' homes if they were unable to travel to the practice for appointments.

Good



### People with long term conditions

This practice is rated as good for the care of patients with long term conditions, for example asthma, diabetes and Chronic Obstructive Pulmonary Disease (COPD), the name for a collection of lung diseases including chronic bronchitis, emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. Patients with long term medical conditions were given longer appointment times and received an annual health review carried out by a GP. Home visits were carried out by clinical staff for those patients who were unable to travel to the surgery for these health reviews. Clinics for podiatry (foot care) and physiotherapy were available.

Good



### Families, children and young people

This practice is rated as good for the care of families, children and young people. The practice held childhood vaccination clinics, antenatal clinics and baby clinics. A midwife came to the practice weekly to see expectant mothers. Appointments were available outside of school hours and children were given priority in the appointment system. The premises were suitable for children and babies. There was also a family planning service and a well woman clinic is due to be launched in the summer of 2015.

Good



### Working age people (including those recently retired and students)

This practice is rated as good for the care of working age patients, recently retired people and students. The practice provided

Good



# Summary of findings

extended opening hours from 8am to 4pm on Saturdays for patients who were unable to visit the practice during the week. The practice also had arrangements for patients to have telephone consultations with a GP. The practice was proactive in working to offer online services and at the time of our visit was developing a new website to facilitate this. Health promotion included healthy eating advice and signposting patients to a nearby smoking cessation support organised by a local pharmacy.

## **People whose circumstances may make them vulnerable**

This practice is rated as good for the care of patients living in vulnerable circumstances. The practice monitored patients with learning disabilities (LD). All patients with learning disabilities were invited to the practice for an annual health check. Flu and pneumonia vaccinations were carried out. The practice regularly worked with multi-disciplinary teams with vulnerable patients. Procedures were in place for staff to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities about sharing information, documenting safeguarding concerns and how to contact the necessary agencies in normal working hours and out of hours. The practice also worked closely with a local carers support group to which carers of patients were referred for additional support.

**Good**



## **People experiencing poor mental health (including people with dementia)**

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice with mental health support and care needs and such patients were invited to the practice for annual health checks. The practice works in partnership with the local Community Mental Health Team and Gateway to identify patients' needs and to provide patients with counselling, support and information. A Gateway worker held sessions within the practice.

**Good**



# Summary of findings

## What people who use the service say

We gathered the views of patients from the practice by looking at 20 CQC comment cards patients had completed and by speaking in person with eight patients. After our inspection we spoke by telephone with two patients who were members of the Patient Participation Group (PPG). The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. This ensured patient views were included in the design and delivery of the service.

Some patients who gave us their views had been patients at the practice for many years. Patients were largely positive about the practice and commented on how professional, friendly and helpful staff and GPs were.

Patients told us they were treated respectfully and compassionately and the GPs, nurses and other staff provided good care. Ten patients told us they felt the practice was either good or excellent. Eleven patients told us how good or excellent they felt GPs and staff were. Three patients told us they felt the principal GP was excellent. Five patients told us they had been disappointed when so many GPs had left the practice over the previous 12 months. Four of those patients said they no longer had concerns following new GPs and staff arriving, the other still felt unsettled by the changes. One patient said the arrival of two new prescribing nurses had made appointments easier to obtain. Before our inspection, four patients contacted the Care Quality Commission (CQC) to say they were concerned about the number of GPs who had left the practice in recent months.

Most patients we spoke with told us the availability of appointments was good. GPs and patients told us that if an appointment was needed in an emergency and all the appointment slots were full, additional appointments

were made on the same day to ensure all patients who required an urgent appointment were seen. One patient told us the practice could improve on the amount of time they spent in the waiting room before they went in for their appointment.

Results from the 2014 GP national patient survey varied against the average for the South Worcestershire Clinical Commissioning Group (CCG). The CCG is a group 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.

For example, a total of 77% of respondents said they usually waited 15 minutes or less after their appointment time to be seen. This was against an average of 65% for the CCG. A total of 95% of patients who responded said the last GP they saw was good at giving them enough time. This was above the CCG average of 90%. Some areas examined were slightly below the average for the CCG. For example, 68% of patients who replied said they found it easy to get through to the practice by telephone. The CCG average was 77%.

In March 2015, the practice carried out its own survey of 100 patients. The number who responded was 37. Of the patients who responded, 86% said reception staff were very helpful or helpful and 90% said staff were either courteous or very courteous. A total of 78% of patients said they were called by their GP for their appointment within 5 minutes of their scheduled appointment time and a further 13.5% were called within five to 10 minutes.

The practice cared for 30 patients in a local care home. Management at the care home told us Barbourne Health Centre gave them an excellent service, cared for their residents well and they had no concerns.

## Areas for improvement



# Summary of findings

## Action the service **SHOULD** take to improve

- Risk assessments should be carried out to determine whether identity details should be obtained for staff employed by the practice before it was registered with the Care Quality Commission (CQC).

# Barbourne Health Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor, a practice manager specialist advisor and a practice nurse specialist advisor.

## Background to Barbourne Health Centre

Barbourne Health Centre is located on the outskirts of Worcester. It has been in its current location for three years and at the time of our inspection had 11,178 patients registered.

The practice provides a range of NHS services including an antenatal clinic and family planning service. The community midwife visits the practice twice weekly. The practice is also registered with the Care Quality Commission (CQC) to undertake minor surgical procedures, although following staff changes, these are not currently being carried out.

The practice has one principal GP and four part time salaried GPs (a mix of male and female), two of whom have been offered partnerships. A new full time salaried GP has been contracted to start work at the practice from September 2015 who has also been offered a partnership. Other clinical staff included three advanced nurse practitioners and three practice nurses and four healthcare assistants. Three nurses are prescribing nurses and can issue prescriptions. A pharmacist is also starting work at

the practice in May 2015 to provide advice and assistance with medicines management. The clinical team are supported by an administrative team led by a practice manager.

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

This was the first time the Care Quality Commission (CQC) had inspected the practice. Based on information we gathered before the inspection, there were a number of concerns raised about the practice and as a result, the practice was being performance monitored by NHS England (NHSE) and the South Worcestershire Clinical Commissioning Group (CCG). A number of concerns had been raised with CQC. These included staffing issues, including a high rate of staff turnover, availability of the lead GP and rates of outpatient attendance.

Data we reviewed showed that the practice was achieving results that were largely average with the South Worcestershire Clinical Commissioning Group (CCG) in most areas. Results from the GP national patient survey were average nationally and for the CCG.

The practice does not provide out of hours services to their own patients. Patients are provided with information about local out of hours services which they can access by using the NHS 111 phone number. The practice also cares for 30 patients in a local care home.

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

# Detailed findings

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

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

## How we carried out this inspection

Before this inspection, we reviewed a range of information we held about Barbourne Health Centre and asked other organisations to share what they knew. These organisations included South Worcestershire Clinical Commissioning Group (CCG), NHS England area team and Healthwatch. We carried out an announced visit on 22 April 2015. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and

administrative staff). We spoke with ten patients who used the service; this included two members of the Patient Participation Group (PPG) who were contacted by telephone after our visit.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

# Are services safe?

## Our findings

### Safe track record

During our inspection of Barbourne Health Centre, we reviewed how the practice identified risks and carried out actions required to improve patient safety. We reviewed documentation for the last twelve months, this included eleven safety incidents. We looked at documents that included safety records, reports of incidents and the minutes of meetings when such matters had been discussed within the practice.

The practice used appropriate methods to enable staff to identify risks and take appropriate action to improve patient safety when needed. These included processes for reporting incidents and an incident checklist to ensure all relevant action had been taken. The practice disseminated information contained within national patient safety alerts to all staff. It was clear the practice also assessed information gathered from clinical audits and health and safety audits it had carried out, with patient safety in mind.

The practice also reviewed safety following comments and complaints they received from patients and staff. For example, we were shown how the practice improved procedures in March 2015 for checking blood test results. A patient's family member complained through NHS England that there had been a delay with being given the results. Checks were put in place to ensure all test results were checked daily and patients informed. The practice had set dates to review this procedure to ensure it was being adhered to.

Records we examined demonstrated the practice had effectively managed safety incidents and had evidence of a safe track record over a longer timescale.

### Learning and improvement from safety incidents

The practice had appropriate systems in place to report, record and monitor all significant events. This included incidents and accidents. We looked at any significant events that had occurred within the last twelve months. Records had been correctly completed within an appropriate time. We also saw when something had gone wrong, in line with practice policy, patients were given an explanation and if necessary, an apology and informed of the actions taken.

We looked at one incident which occurred late last year when the practice received a letter from a hospital

consultant requesting a patient received a blood test. This was not carried out as the named GP was on annual leave and was identified when the consultant chased up the request. Following this, the practice amended its process for dealing with such requests and reviewed the situation to ensure it did not happen again. This and all other recorded incidents and significant events were discussed at practice meetings. This included reviewing progress made on actions that had arisen from previous incidents.

During our inspection, we saw the practice had learned from the incidents and significant events that had occurred. Findings and conclusions had been shared with relevant staff and all staff we spoke with, both clinical and non-clinical, knew the reporting procedure and had completed the checklist when incidents occurred to ensure all relevant action had been taken.

We also saw the practice discussed national patient safety alerts in staff meetings, along with any action to take as a result of each safety alert.

### Reliable safety systems and processes including safeguarding

The practice had appropriate procedures in place to ensure any risks to vulnerable children, young people and adults were identified and any action required was carried out in a timely way. All staff we spoke with were fully aware of these procedures and knew what they should do when a situation occurred. They had knowledge of who the incident should be reported to within the practice, of the documentation that needed to be completed and of the relevant agencies that needed to be contacted, both within working hours and out of office hours. We saw relevant contact details were clearly available. The GP discussed the system used to highlight vulnerable patients on the practice's patient records.

Staff we spoke with had received safeguarding training and as a result knew how to recognise signs of potential abuse in older people, adults and children. We also asked staff about the training they had received. We looked at the training records held by the practice. This demonstrated all staff had received appropriate training in safeguarding that was specific to their individual role within the practice. The role specific training included the practice GP who was safeguarding lead. The practice could demonstrate they had the necessary training to enable them to carry out this role and showed us relevant training certificates.

## Are services safe?

GPs told us they had a good working relationship with relevant safeguarding partner agencies, such as the Worcestershire County Council Social Services department. We saw all safeguarding concerns had been discussed at regular multi-disciplinary team meetings.

The practice had a chaperone policy in place for patients and staff. 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. Notices about this were clearly displayed for patients to see within the waiting room and in consulting rooms. All nursing staff had been fully trained to act as chaperones and those we spoke with correctly described their responsibility.

### Medicines management

Medicines kept within the treatment rooms and medicine refrigerators were correctly and securely stored. This included ensuring medicines were stored at the correct temperature. Procedures were in place to govern this and the medicines refrigerator had its temperature checked manually and recorded on a daily basis in line with this procedure. As an additional check, digital recording was also used and the results downloaded to the practice's computer system every week.

Guidelines were also in place to detail action to be taken if a power failure occurred. There were also procedures in place to ensure 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. The practice did not hold stocks of controlled drugs. Medicines were only accessible to appropriate staff and we saw training records to confirm staff had received appropriate medicines management training when necessary. Vaccines were administered in accordance with directions that had been produced in line with legal requirements and national guidance. The practice had reviewed its medicines guidelines in January 2015. A pharmacist was due to start work at the practice in May 2015 to provide advice and assistance with medicines management to ensure medicines reviews were carried out promptly and effectively.

GPs told us how all prescriptions were reviewed and signed by the GP before they were given to the patient. Blank prescription forms were stored in line with national guidance as these were tracked through the practice and kept securely at all times.

### Cleanliness and infection control

We saw how Barbourne Health Centre had appropriate infection control procedures in place. This included the infection control policy and supporting policies for areas such as the safe use and disposal of sharps; use of personal protective equipment (PPE); management of spills of blood and bodily fluid. This enabled staff to plan and implement measures for infection control within the practice and effectively assess risks to patients and staff. To enable this to be carried out, an advanced nurse practitioner had been appointed as the lead for infection control. They had received relevant training for this role which enabled them to provide advice on infection control measures within the practice and provide training to staff. We looked at training records. They demonstrated all staff had received role specific induction training about infection control, followed by on-going training and updates when required.

We looked at the infection control audit that had been carried out by the infection control lead in March 2015. This had not identified any actions that needed to be completed. This had also been undertaken annually in previous years. Any improvements identified for action had been completed on time.

Arrangements were in place to ensure the safe disposal of clinical waste and sharps, for example, needles and blades. We saw evidence that their disposal was arranged through an appropriate company.

During our inspection we saw the premises were visibly clean and tidy. Cleaning schedules were in place and cleaning records were kept. The practice employed its own cleaner. Five patients we spoke with told us they always found the practice to be clean and tidy. We saw 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 also available in treatment rooms.

There was a policy in place for the management, testing and investigation of legionella; this is a germ found in the environment which can contaminate water systems in buildings. We saw records that confirmed the practice carried out annual checks in line with this policy to reduce the risk of infection to staff and patients.

### Equipment

We observed that staff had relevant equipment to enable them to carry out diagnostic examinations, assessments

## Are services safe?

and treatments. Staff we spoke with explained all equipment was tested and maintained regularly. We also saw equipment maintenance logs and records to confirm this. Portable electrical equipment was regularly tested; the last occasion was in February 2015.

### Staffing & Recruitment

Barbourne Health Centre had appropriate measures in place to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff on duty. A weekly staff rota was compiled several weeks in advance and this was reviewed on a weekly basis to take account of any last minute changes that were needed. This took account of any additional staffing requirements that might be needed, for example, immediately following a bank holiday or when staff were on annual leave. There was always a member of clinical staff on duty when the practice was open. Some administrative staff were also part time; this ensured staff cover was available if a team member was unexpectedly absent.

We asked the principal GP about the numbers of GPs and staff who had left the practice during the last 12 months. He discussed the detail surrounding the departure of clinical staff and non-clinical staff from the practice. We were shown there were no common reasons for staff leaving. The GP said it had been very unfortunate for the practice and had created a very difficult time for staff and patients. They felt the practice could now look to the future. Staff we spoke with were positive about the changes that had occurred and now felt the practice was heading in the right direction. Some staff told us it was unsettling at the time colleagues were leaving, but they now had no concerns and were confident about the future.

To replace the clinical staff, the practice had employed an additional four part time salaried GPs, two of whom had been offered partnerships. A full time salaried GP had been contracted to start at the practice in September 2015 after serving notice at their current practice. They had also been offered a partnership. At the time of our inspection, a male locum GP was due to be employed to increase the number of appointments available with a male GP. A service level agreement was in place to support this appointment.

Two additional advanced nurse practitioners had also been recently employed. These were nurses who could issue

prescriptions and were specifically chosen to ease pressure on patient appointments as a result. Key senior administrative staff had also joined the practice from 1 April 2015 to complete the staff team.

During 2014, staff had been brought in on a temporary basis at times to fill shortfalls in staffing at Barbourne Health Centre. GPs and staff told us this was no longer the case and all staff at the practice were now contracted to work there on a permanent basis. Management had issued staff with new contracts of employment from April 2015 to ensure all staff had similar terms and conditions, as these had previously varied. Staff we spoke with had not been concerned about these new contracts.

Practice staffing was also reviewed to take into account the needs of the local population and ensure sufficient staff were available to meet demand. Staff we spoke with confirmed this was the case and most patients we spoke with told us they could usually get an appointment when they needed one. The practice carried out regular audits of patient appointments to ensure patient demand was being met. This demonstrated the practice offered the correct number of GP and practice nurse appointments per week for the size of the practice.

The GP told us that in the event of a shortage of GPs, locum GPs could be used and a service level agreement was in place for this. A shortage of GPs was also one of the risks covered by the practice business continuity plan. This would help to ensure sufficient GPs were available to continue to meet the needs of the practice patients.

The practice had a comprehensive recruitment policy in place. This gave details of the pre-employment checks the practice had to carry out on a successful applicant before that person could start work in the practice. They included checks on identification, references and a criminal record check with the Disclosure and Barring Service (DBS). All staff, including administrative staff, were DBS checked.

During our inspection we looked at a selection of staff files for a GP, administrative staff and nurses. The records we viewed demonstrated the recruitment procedure had been followed. Risk assessments were not carried out to determine whether identity details should be obtained for staff employed by the practice before it was registered with CQC.

## Are services safe?

### Monitoring safety and responding to risk

The practice carried out regular health and safety checks. This included areas such as checks of the building, medicines management, dealing with emergencies and equipment. These were part of the procedures the practice had put in place under its health and safety policy to ensure all risks to patients and staff were identified and monitored effectively.

All risks were assessed and recorded in a risk log and rated with appropriate actions recorded to reduce and manage each risk. We saw that identified risks were discussed during staff meetings. We also saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

There was appropriate information about health and safety clearly displayed for all staff to see and the practice manager was the designated health and safety representative and had received training for this additional duty.

### Arrangements to deal with emergencies and major incidents

Barbourne Health Centre had appropriate arrangements in place to manage emergencies. We saw records held by the

practice that showed all staff had received training in basic life support. There was emergency equipment available within the practice. This included oxygen and an automated external defibrillator, which was used to attempt to restart a person's heart in an emergency. Staff we spoke with knew where this equipment was kept, records indicated it was checked regularly and we saw records to confirm staff had been trained to use it.

Emergency medicines were kept in a secure area of the practice. Staff knew the location. We saw medicines which included those for the treatment of cardiac arrest and anaphylaxis (an allergic reaction). The practice had processes in place to check whether emergency medicines were within their expiry date and therefore suitable for use. We checked the dates on a selection of the medicines and found they were in date and fit for use.

The practice had a service continuity plan in place which was regularly reviewed in the light of any changing situations. This dealt with emergencies that could impact on the daily running of the practice, for example power failure, adverse weather, including flooding, unplanned sickness and access to the building. An annual fire risk assessment had also been carried out. This included actions required to maintain fire safety.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment, care & treatment in line with standards

Barbourne Health Centre had appropriate systems in place to assess the needs of patients and then deliver care and treatment in line with medical guidelines and the wishes of the individual patient. GPs told us how they used guidance issued by the National Institute for Health and Care Excellence (NICE) during the diagnosis and treatment of patients' medical conditions. This ensured patients received care based on the latest medical evidence and up to date tests and treatments. This included any follow up treatment needed after their initial appointment.

GPs managed the care and treatment received by patients with long term conditions. Appropriate systems were in place to ensure such patients were reviewed at least annually. Conditions included diabetes, asthma and hypertension (high blood pressure). In most areas, percentages for patient reviews were average or higher than those within the South Worcestershire Clinical Commissioning Group (CCG). This is a group 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.

### Management, monitoring and improving outcomes for people

The practice used completed clinical audit cycles to monitor its performance with patients and identify areas that needed to be improved. The practice had set dates to repeat these audits to ensure improvements were continuously being made. Some of this assessment was undertaken for the Quality and Outcomes Framework (QOF). This is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually.

The practice was unable to provide many examples of completed audits at the time of our inspection, but a selection of audits and schedule that gave dates when future audits would be carried out was sent to the Care Quality Commission (CQC) within 48 hours.

Examples of completed clinical audits included a medicine used to treat rheumatoid arthritis. When the audit was first

carried out in September 2014, three patients were identified who had not received the required regular blood test. The records were checked of all patients receiving the medication to ensure all had the required alerts set up on their medical records to ensure blood was checked at the required interval. When the audit was carried out again in April 2015, all patients had been reviewed and had dates set for further reviews in the future.

Over the last twelve months, 88.74% of patients with diabetes had been reviewed and 93.69% of patients with Chronic Obstructive Pulmonary Disease (COPD), a lung condition were reviewed. Of the 7236 working age patients registered at the practice, 3656 had their blood pressure taken during the last twelve months, a total of 50.5%. The most vulnerable 2% of elderly patients had care plans in place in line with NHS guidelines. This included those within the care home the practice served. The principal GP explained how the practice liaised with the care home and home carers when appropriate. Patients who required palliative care (care for the terminally ill and their families) were regularly reviewed. Of those patients, 98.75% had been reviewed within the last 12 months and we saw evidence of discussions that took place in the minutes of palliative care meetings held regularly.

We were shown how the practice had identified and discussed concerns that arose from the numbers of patients who received new oral anticoagulant (blood thinning) medication (NAOC) who had not had a medicines review since they started the medication. In September 2014, 14 out of 35 patients had been reviewed. As a result, the practice introduced a patient recall system for these patients with an annual medicines review to ensure they were not missed. When the audit was carried out again in April 2015, 23 patients had then been due for an annual review and all 23 patients had been reviewed. Dates were in place to review the remainder of the patients who received NAOCs at the appropriate time. We were satisfied the practice identified and took appropriate action when areas of concern were identified.

### Effective staffing

The practice staff included medical, nursing, managerial and administrative teams. During our inspection we looked at a range of staff training records. It was clear staff were up to date with training, for example, in basic life support and safeguarding. We saw GPs were up to date with their yearly continuing professional development requirements. All GPs



# Are services effective?

## (for example, treatment is effective)

had either 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). Staff also had annual appraisals. These were used to identify training needs and action plans were formed. Staff we spoke with confirmed the practice provided training and funding for relevant courses. Training was prioritised and each staff member had a self-evaluation workbook for the in-house training provided by the practice. This was reviewed as part of the staff appraisal scheme.

GPs, nursing and staff had detailed job descriptions and the practice was able to demonstrate they were trained to carry out these duties. For example, administration of vaccines. We were shown certificates to demonstrate that they had appropriate training to fulfil these roles.

### Working with colleagues and other services

The practice worked closely with other services to ensure patients' needs were met and more complex medical needs were effectively managed. This included the receipt of blood test results, X-rays results and information from the local hospital and out-of-hours GP services, for example discharge summaries and records of treatment. Identifiable staff read and acted on this information when it was received. Staff concerned understood their roles.

Records confirmed the practice worked closely with the community midwife service, health visitors and community mental health professionals, including Gateway, community drug teams and the local St Richards Hospice for patients on the palliative care register who received care there. Clinics were held for blood testing, anti-coagulant (blood thinning) testing and family planning.

There were weekly clinical meetings to discuss concerns. This included the needs of complex patients, for example those with end of life care needs or children who are at risk of harm. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. We saw minutes of these meetings and evidence that clinical updates, significant events and emergency admissions to hospital were discussed and actions identified.

The waiting room contained a large selection of leaflets about locally available services. Most of these were

available in the other languages represented within the local community. Relevant information was also displayed on a large screen computer monitor within the patient waiting room, this was also multi-lingual.

### Information sharing

Practice staff used electronic patient records to document and manage patient care. The package enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. All staff were fully trained on this.

The practice used recognised electronic systems to share communications with other organisations. As an example, there was a shared system with the local GP out-of-hours provider. This ensured patient data was shared in a secure and timely way. The practice received details of all out-of-hours attendances before 8am on the next working day in line with national guidance. A system was also in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

### Consent to care and treatment

The practice had a process to ask for, record and review consent decisions that were needed from patients. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. Some patients we spoke with confirmed this. At the time of our inspection, the practice had stopped carrying out minor surgery due to changes to staff and had yet to make a decision about whether this would be reinstated in the future.

Processes were also in place to obtain signed consent from parents of children receiving immunisations. Clinical staff we spoke with recognised the need to obtain consent from parents and what to do if consent was needed when a parent wasn't available. Information about potential side effects of immunisations was available to reassure parents.

The GP and nurses we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to

# Are services effective?

(for example, treatment is effective)

consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options. Staff we spoke with showed they had an understanding of the Mental Capacity Act 2005 and appropriate knowledge about best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

When patients needed an interpreter, the practice staff were able to use an interpretation service. However staff told us, if a patient needed an interpreter, they usually brought a family member with them.

## Health Promotion & Prevention

The practice offered NHS health checks to all its patients aged between 40 and 75 years. Over the last 12 months, 1246 checks had been carried out on patients; this represented 33.79% of the patients who were eligible. This was below the average for the South Worcestershire Clinical Commissioning Group (CCG). The practice recognised the need to increase this percentage and

demonstrated plans to do so with the recent employment of two new practice nurses. This included an increased number of practice nurse appointments and increased follow up of patients who failed to attend. This also applied to the practice's performance for cervical cancer screening. The uptake was below the CCG average at 12.95%. The total number of patients screened in the last year were 720 out of 5559 who were eligible. The percentage of childhood vaccinations carried out was 83%, above the NHS England target of 80%.

When patients registered with the practice for the first time, they were offered an appointment with a practice nurse. If the practice nurse identified any medical concerns, the patient was referred to the GP or another healthcare professional if more appropriate.

We were shown work the practice had carried out to identify and promote particular health needs within the local community. For example, patients who smoked were referred for smoking cessation support at a nearby pharmacy and patients could be referred to a local service for weight checks and advice. Appointments were also available within the practice with a physiotherapist employed by a local organisation.

# Are services caring?

## Our findings

### **Respect, Dignity, Compassion & Empathy**

Patients we spoke with and patients who completed comment cards, were very happy with the care they received and any follow-up needed once they obtained an appointment. Patients felt they were consistently treated with dignity and respect by all members of staff. Patients we spoke with also confirmed the GPs and practice staff were friendly and helpful. The GPs were also described as excellent by patients. During our inspection we saw how staff interacted with patients, both in person and over the telephone. Staff were helpful and empathetic, warm and understanding towards patients and we observed good rapport with patients when a GP came into the patient waiting room.

Patients we spoke with and patients who completed comment cards were satisfied with the care they received from the practice. Before our inspection, four patients contacted the Care Quality Commission (CQC) to say they were concerned about the number of GPs who had left the practice in recent months.

During our inspection, five patients told us they had been disappointed when so many GPs had left the practice over the previous 12 months. Four of those patients said they no longer had concerns following new GPs and staff arriving, the other still felt unsettled by the changes. Three patients mentioned the principal GP by name and felt they were excellent.

Clinical staff told us how patients' privacy and dignity was respected by staff during examinations. We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

We looked at the results of the 2014 GP patient survey. A total of 263 surveys were sent out and 114 sent back. This was a completion rate of 43.3% and represented 1.01% of the total patient list. The results of the survey varied against the average for the South Worcestershire Clinical Commissioning Group (CCG). This is a group 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. For example, 95% of respondents said the last GP they saw or spoke to was good at giving them enough time. The CCG average was 90%. A total of 66% of respondents said they were satisfied with the practice opening hours, against a CCG average of 76%.

In March 2015, 37 patients completed a patient survey, issued by the practice to 100 of their patients. Of the patients who replied, 100% said dignity and respect shown by GPs was either excellent (89%) or good (11%).

### **Care planning and involvement in decisions about care and treatment**

During our inspection, we saw patients were given appropriate support and information so they could make informed decisions about their care and treatment needs. Staff told us how this was discussed with patients before any treatment started and how they assessed what care and support each patient needed. When we spoke with the GP, it was explained how they discussed any proposed changes to treatment or medication with each patient at the time a proposed change was identified. The GP explained how they kept patients fully informed during consultations and treated patients with consideration and respect. In the 2014 GP national patient survey, 92% of patients who responded said the last GP they saw or spoke to was good at explaining tests and treatments. This was against a CCG average of 90%. Patients we spoke with told us they felt listened to by their GP and the practice staff. Some patients indicated that they had long term health conditions and said that they were seen regularly.

### **Patient/carer support to cope emotionally with care and treatment**

We did not speak with or receive any comment cards from patients who were also carers. However the GP and staff described the support they provide for carers and links to refer patients to appropriate organisations, including Worcester Carers Association. Information about them was also displayed in the waiting room. The practice also referred patients to a counselling service for professional support after bereavement.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

Barbourne Health Centre had appropriate systems in place to monitor and maintain its service level. The practice responded to the needs of its patients and kept this under review. GPs and staff understood the needs of the practice population and systems were in place to address any identified needs in the way services were delivered. GPs provided examples of how the practice responded to the needs of the local community. For example, by providing Saturday appointments for patients unable to get to the surgery during the week.

The needs of patients with long term conditions were kept under review. The practice had registers of patients with mental health support and care needs and with learning disabilities. Each patient on the registers was invited for an annual review. Staff told us they had a good working relationship with the local community mental health team.

We looked at minutes of meetings that discussed patient capacity and demand. As a result, changes were made to staffing and clinic times when required. During the first part of 2015, the practice had identified areas of improvement that could be made to improve the experience of patients. This included the employment of two new advanced nurse practitioners to increase the availability of nurse appointments. This has also enabled GPs to spend longer reviewing patients with long term conditions by offering longer appointment times when this was needed.

The practice had an established Patient Participation Group (PPG). This held quarterly meetings at the practice. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured that patients' views were included in the design and delivery of the service. We saw how the PPG had been involved with the recent patient survey.

We spoke with two PPG members who were also patients at the practice. One felt the practice had recently made great improvements and had no concerns. They also told us that some patients had expressed theories about why so many GPs had left the practice during 2014, but felt there were no current concerns. The other PPG member said they were still unsettled about the changes that had occurred and said the PPG hadn't been consulted about

the reasons for GPs leaving. When we raised this with the principal GP and practice manager, we were given explanations about the individual circumstances of GPs who had left the practice and were told that information that could be shared, had been shared with the PPG.

### Tackling inequity and promoting equality

Of the patients who used Barbourne Health Centre, the majority spoke English as their first language. We saw some information leaflets were available in other languages in the waiting room and a translation service could be used if required. There was an induction loop to help patients who used hearing aids and these patients could be invited into a private room for discussion if a quieter environment was helpful.

### Access to the service

The practice opened from 8am to 6.30pm every weekday and on Saturdays from 8am to 4pm. Cover was provided by the out of hours service when the practice was closed and was accessible by patients telephoning the NHS 111 service. GPs and patients told us that if an appointment was needed in an emergency and all the appointment slots were full, additional appointments were made on the same day to ensure all patients who required an urgent appointment were seen. Telephone consultations were also available. The number of practice nurse appointments had recently been increased by the employment of two new advanced nurse practitioners who could issue prescriptions. This enabled the practice to increase the number of GP and practice nurse appointments it offered throughout the week.

Appointments could be booked for the same day, for within two weeks' time or further ahead. Patients could make appointments and order repeat prescriptions through an on-line service. Home visits were available for patients who were unable to go to the practice.

The information from CQC comment cards and patients we spoke with indicated that the service was easily accessible and that patients were always able to get an appointment on the same day they phoned if this was needed. Following the 2014 GP national patient survey which showed that 68% of respondents found it easy to get through to this surgery by phone, against a CCG average of 77%, the practice had improved its on-line appointment booking facility and had promoted this more. The practice intended to examine this again in the next patient survey to see if further improvements were needed.

# Are services responsive to people's needs?

(for example, to feedback?)

## Listening and learning from concerns & complaints

The practice received and acted upon concerns and complaints from patients. This was in line with guidelines and contractual obligations issued for all GPs in England. The practice manager handled all complaints in the practice. The complaints procedure was clearly displayed within the waiting room, along with clear information on how a patient could make a complaint if they wished to do so. This was also printed within the patient information leaflet. All the patients we spoke with said they had never had to raise a formal complaint. It was clear that verbal complaints were dealt with in the same way as written ones. The practice manager told us, if a patient telephoned the practice to complain, they would immediately take the

call if available and attempt to resolve the concerns immediately if possible. The practice compiled a complaints summary which summarised the complaints for each year which was used to identify any trends.

During our inspection, we looked to see whether the practice adhered to its complaints policy. The practice had received 27 complaints within the last 12 months. None related to safety incidents and there were no re-occurring themes. We found that the complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. One complaint we examined related to the high turnover of GPs at the practice. Management had replied to the patient outlining the reasons for the sudden changes and measures that were in place to recruit more GPs and improve the service.

# Are services well-led?

Good 

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

## Our findings

### Vision and Strategy

The practice aimed to provide a safe and caring service with a cohesive and well-functioning team. GPs and staff we spoke with were very positive about this vision and understood how they fitted into it. GPs and staff explained how the priority had been to rebuild the staff team after the difficulties the practice went through during the last twelve months and felt this had now been completed. The next priority for the practice was to identify areas to further improve its service to patients. The principal GP explained one of their priorities was to appoint more GP partners and explained that offers had been made to two current GPs and to the GP due to start at the practice in September 2015.

The practice held weekly clinical meetings and leadership developments within the practice was discussed as matters arose. We looked at minutes of some of these meetings and saw they discussed topics such as forward planning, practice objectives, potential future partnerships and vision. The practice regularly reviewed its objectives during staff meetings. The principal GP told us the practice aimed to provide a high quality safe service to patients with consistent staffing.

### Governance Arrangements

The practice used information from a variety of sources to help them assess and monitor their performance. This included information from their Quality and Outcomes Framework (QOF) and the Clinical Commissioning Group. QOF is an annual incentive programme designed to reward doctors for implementing good practice. The practice had improved their performance within the South Worcestershire Clinical Commissioning Group (CCG) for QOF. As a result its performance was now average for the CCG, having been below average last year, after performing well in previous years.

The principal GP had lead roles with specific areas of interest and expertise. This included governance with a clearly defined lead management role and responsibility. The lead GP discussed with us how lead roles would be reviewed and shared as soon as further GP partners had been appointed later in 2015. During the inspection we found that all members of the team we spoke with understood these lead roles and responsibilities. The practice held a regular meeting of clinical staff, this

included discussions about any significant event analyses (SEAs) that had been completed. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team.

### Leadership, openness and transparency

Staff described GPs and management as being very open and honest. During our inspection we found the principal GP and practice management to be very open about the difficulties the practice had been through over the last 12 months. Staff we spoke with felt supported by GPs and management and told us they were looking forward to future developments.

### Practice seeks and acts on feedback from users, public and staff

The practice had a Patient Participation Group (PPG). This met quarterly at the practice. The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. This ensured patient' views were included in the design and delivery of the service. We saw example of information that had been circulated to the PPG. This included discussion about the patient survey carried out by the practice earlier in 2015.

All the patients we spoke with on the day of our inspection told us they received an excellent service from the practice. The practice had closely monitored patient comments and had taken into account comments received from patients about their concerns, for example, the availability of appointments for practice nurses. In addition to employing two additional practice nurses, the practice had introduced a regular patient appointment audit to ensure capacity met demand.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. We saw that there were systems in place for the practice to analyse the results of the survey so that any issues identified were addressed and discussed with all staff members.

In March 2015, the practice carried out a survey of 100 patients. The number who responded was 37. Of the patients who responded, 86% said reception staff were very helpful or helpful and 90% said staff were either courteous or very courteous. 66% of patients said they were satisfied



# Are services well-led?

Good 

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

with the practice's opening hours, against a CCG average of 76% and 68% of patients found it easy to get through to the practice on telephone, compared with a CCG average of 77%. Following these survey results, the practice made changes to its telephone system and to its on-line appointment booking facility.

## **Management lead through learning & improvement**

We saw evidence that the practice was focussed on quality, improvement and learning. The whole practice team had sessions each year for 'protected learning'. This was used

for training and to give staff the opportunity to spend time together. For example, within the last 12 months, safeguarding and emergency first aid training had been carried out. Clinical staff had protected learning time for training prioritised and each staff member had a self-evaluation workbook for the in-house training provided by the practice. This was reviewed as part of the staff appraisal scheme. The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.