Spring Gardens Group Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Spring Gardens Group Medical Practice on 4 May 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded.
- The practice was using the National Reporting and Learning System (NRLS). This is a means of sharing lessons learned from safety incidents.
- Staffing levels were monitored to ensure they matched patients' needs. Due to some staff leaving the practice there was a shortage of clinical staff. Recently an advanced nurse practitioner and a practice nurse had been recruited and efforts were being made to employ a GP.
- Safe arrangements were in place for staff recruitment that protected patients from risks of harm. Risks to patients were assessed and well managed.
- The practice used innovative and proactive methods to improve patient outcomes. Clinical research and audits led to improved patient care.
- Research was on-going regarding patients who experienced poor mental health. Personalised care plans were put in place and a support system for relatives of these patients.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training had been identified and planned. The roles of nursing staff were constantly being expanded following appropriate training. This resulted in a positive impact on GPs' workloads.
- Patients told us they were treated with compassion, dignity and respect and they were involved in decisions about their treatment.
- Information about how to make a complaint was readily available and easy to understand.
- There was a clear leadership structure and staff told us they felt well supported by senior staff. Management proactively sought feedback from patients which it acted on.

Summary of findings

- A number of initiatives completed had resulted in improved outcomes for patients. For example, the developed template for patients who required end of life care. An on-going initiative involved a senior manager working with other practices to ensure there was a consistent approach for the use of computer flagging for identification of patients who had specific needs. This would be beneficial to patients who moved between practices.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system for reporting and recording significant events, and lessons learnt were shared throughout the practice at regular meetings. When there were preventable unintended or unexpected safety incidents patients received an apology and informed of any actions taken to prevent the same thing from happening.
- Information about safety was recorded, monitored appropriately, reviewed and addressed.
- The practice had clearly defined and embedded systems in place to keep patients safe and safeguarded from abuse. Staff had received training that was relevant to their role.
- The practice had a safe system for managing medicines and safe prescribing to ensure that patients only received the medicines they needed.
- We found that senior staff promoted patient safety by adhering to the policy and procedure for recruiting staff.
- Staffing levels were regularly monitored to ensure there were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Clinical staff referred to guidance from National Institute for Health and Care Excellence (NICE) and local guidelines were used routinely as part of their work.
- Patients' needs were assessed and care was planned and delivered in line with current legislation.
- The clinical staff used innovative and proactive methods to improve outcomes for patients who experienced poor mental health.
- Support was provided for relatives of patients who experienced poor mental health to assist them in managing and reducing their stress levels.
- Staff had received training appropriate to their role and potential enhanced skills had been recognised and planned for and training put in place.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to provide up to date, appropriate and seamless care for patients.

Summary of findings

- An officer from Age UK regularly worked alongside staff in providing a translation service for the Asian population group. They used the opportunity to encourage healthy life styles and they explained to patients why they needed to attend for reviews of their long term conditions.
- A GP gave presentations twice a year to a local school on sex education.
- The practice was instrumental in setting up a pilot email cardiology (heart) advice service.
- The practice was the lead in the Region in carrying out research that led to improved patient care. The results were shared with other practices.
- Senior staff worked with the Clinical Commissioning Group (CCG) in the development of care pathways for end of life care, chronic obstructive pulmonary disease (COPD) and asthma schemes.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Staff ensured that patients' dignity and privacy were protected and patients we spoke with confirmed this.
- Patients had their needs explained to them and they told us they were involved with decisions about their treatment.
- We saw that staff treated patients with kindness and respect and maintained confidentiality.
- Information for patients about the services available to them was easy to understand and accessible.
- There was a strong focus on carers and staff had regular contact with an officer from the Worcestershire Carers Association. Carers were encouraged to identify themselves. Clinical staff provided them with guidance, signposted them to a range of support groups and ensured their health needs were met. The community champion system also provided assistance in this area in offering no-clinical advice and support.
- Data published in January 2016 from the national patient survey showed that patients rated the practice lower than others for several aspects of their care. Most patients we spoke with on the day were complimentary about their care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Staff had reviewed the needs of the local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to patient care and treatment.

Summary of findings

- Most patients told us it that it was easy to make an appointment; some told us it was sometimes difficult. On the day of our inspection we saw that some appointments for the day had not been filled.
- The practice provided enhanced services. For example avoiding unplanned admissions by carrying out health reviews and development of individual care plans and minor surgery.
- Information about how to complain was available and easy to understand.
- The Proactive Care Team (PACT) assessed 2% of the most frail patients to improve their health and prevent unnecessary admissions to hospital. PACT staff were employed by the Clinical Commissioning Group whose objective was to make improvements through general practices.
- Patients who experienced poor memory were assessed in order to make early diagnosis of those who had dementia so that a prompt support system could be put in place.
- Clinical staff were carrying out a pilot that monitored the health of patients who experienced poor mental health and a tool kit was in place to provide support to relatives of these patients.
- A Gateway worker held two sessions per week at the practice and assessed patients who experienced poor mental health. They gave advice and support to improve patient's life styles.
- Senior staff worked with the Clinical Commissioning Group (CCG) in the development of care pathways for end of life care, chronic obstructive pulmonary disease (COPD) and asthma schemes.
- A senior nurse had provided two presentations to patients who had diabetes and stressed the importance of attending for their reviews. Plans were in place to repeat these events.
- Staff had visited a nearby travellers' campsite and provided advice about how the practice could support them.
- Evidence showed that senior staff responded quickly and appropriately when issues were raised by patients. Where necessary apologies were provided and improvements made.
- Learning from complaints was shared with all staff and other stakeholders.
- There was a shortage of a GP. Senior staff were seeking to recruit a GP and had filled the nurse vacancies. Nursing staff were undertaking extra training to enhance their roles, which provided relief to GP's workload.

Are services well-led?

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

Good

Summary of findings

- Staff were clear about the vision and their responsibilities in relation to this. Future challenges had been identified and proposals put in place to address them.
- The practice had actively participated in development of the end of life care programme and this had been rolled out to other practices. The practice manager was working with other practices in developing uniformity in the computer flagging system (identifying those at risk or who needed specialist care) for when patients moved between services.
- There was a distinct leadership structure and staff were well supported by management.
- Meetings were held with practices to share information and identify areas where improvements could be made.
- There were policies and procedures to govern activity and these were accessible to all staff.
- Senior staff actively sought patient feedback about the services they received and where possible made changes to improve them.
- The Patient Participation Group (PPG) were active. A PPG is a group of patients who represent the views of patients and work with practice staff to improvement services and the quality of care.

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

Good

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

- Practice staff offered proactive, personalised care to meet the needs of older patients.
- Staff kept up to date registers of patients' health conditions and information was held to alert staff if a patient had complex needs.
- Home visits were offered to those who were unable to access the practice and patients with enhanced needs had prompt access to appointments.
- Practice staff worked with other agencies and health providers to provide patient support. The Proactive Care Team (PACT) assessed frail patients in their own home and those in care homes to ensure their health needs were met.
- Practice staff worked with other agencies and health providers to provide patient support.
- GPs made regular visits to a care home where practice patients resided to monitor their health needs.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management.
- A senior nurse had provided two presentations to patients who had diabetes and stressed the importance of attending for their reviews. Plans were in place to repeat these events.
- Longer appointments and home visits were available when needed.
- Patients with long-term conditions had structured annual reviews to check that their health and medicine needs were being met. Where necessary reviews were carried out more often.
- Patients who had more than one long term condition received their reviews through single appointments to reduce the number of times they needed to visit the practice.
- Clinical staff worked with health and care professionals to deliver a multidisciplinary package of care.
- An officer from Age UK regularly attended the practice to provide a translation service and to emphasize why reviews were necessary.

Summary of findings

- All patients had a review following their discharge from hospital to ensure that all of their care needs were met.

Families, children and young people

Good

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.
- Alerts were put onto the electronic record when safeguarding concerns were raised.
- There was regular meetings and liaison with the health visitors to review those children who were considered to be at risk of harm.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Extended hours were in place that allowed children to be seen outside of school hours. Appointments were available from 7.30am every Tuesday and until 8pm every Wednesday. Patients could be seen during a number of Saturdays each year between 8am and 11am.

Working age people (including those recently retired and students)

Good

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

- The practice had adjusted its services to accommodate the needs of this population group.
- Extended hours were available and telephone consultations for those patients who found it difficult to attend the practice or if they were unsure whether they needed a face to face appointment.
- Online services were available for booking appointments and ordering repeat prescriptions.
- The practice website gave advice to patients about how to treat minor ailments without the need to be seen by a GP.
- Data told us that some patients had failed to attend for cervical screening. Staff had adopted various methods in explaining the necessity of this service and encouraged patients to attend.

People whose circumstances may make them vulnerable

Good

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

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including those who had a learning disability. Patients who had a learning disability received their reviews by the same nurse and GP each time in order to build their confidence and communications with staff. All patients who had a learning disability had received their annual reviews.
- Practice staff regularly worked with multi-disciplinary teams in the case management of vulnerable patients.
- These patients had been signposted to additional support services. The community champions ('time to talk') pilot supported this process.
- Staff had visited a nearby traveller's campsite and provided advice about how the practice could support them.
- Staff knew how to recognise signs of abuse, the actions they should take and their responsibilities regarding information sharing.
- There was a clinical lead for dealing with vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

- Most patients who experience poor mental health had received an annual physical health check.
- Practice staff regularly worked with multi-disciplinary teams in the case management of patients who experience poor mental health, including those with dementia.
- GPs carried out assessments of patients who experienced memory loss in order to capture early diagnosis of dementia. Data published in January 2016 told us that 97% of these patients had attended the practice for their reviews. Patients who had dementia were investigated and referred to the early intervention service for advice and support. They were encouraged to attend exercise classes to help them in maintaining healthy lifestyles.
- Sessions were held twice a week at the practice by the Gateway mental health team who provided advice, support and signposting for patients who were experiencing poor mental health.
- Clinical staff were carrying out research projects. One concerned physical health checks for a specific disorder of

patients' who experienced poor mental health. This enabled staff to put a care package in place that provided health and social care support systems in place to promote patients well-being.

- Another project involved the assessment of cardiovascular risk to these patients. The other research concerned Relatives Education and Coping Toolkit (REACT). It provided on-line peer support and a toolkit for assistance with the aim of reducing the stress levels experienced by relatives.
- All patients who experienced severe mental health illness had care plans in place that were regularly reviewed. Care plans included physical health disorders. These patients were seen by their own GP for continuity of care and were offered same day appointments to ensure they received a prompt service.
- Referrals to other health professionals were made when necessary.
- Data published in January 2016 informed that 25% of patients who experienced depression had not attended the practice for their reviews. Although staff encouraged patients to attend the practice they told us that patients did not attend. The attendance rates had been discussed with other practices in an effort of finding ways of addressing this problem.

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016 showed the practice results were mixed in comparison with local and national averages. There were 118 responses, this equated to a 43% response rate.

- 88% of patients found the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 85% of patients said last time they spoke with a GP they were good at giving them enough time compared with a CCG average of 90% and a national average of 87%.
- 70% of patients found it easy to get through to this surgery by phone compared with a CCG average of 76% and a national average of 73%.
- 86% of patients said the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 60% of patients felt they did not normally have to wait too long to be seen compared with a CCG average of 60% and a national average of 58%.

As a result of the survey the practice was adapting the telephone system to increase the number of lines that will be available to patients.

During our inspection we spoke with 10 patients and one who was a carer. They told us they were satisfied with the care and treatment they received. Some patients told us they could not get an appointment when they felt they needed one. We looked at the appointments system at the end of the morning sessions and saw that there were appointments still available. Part of the role of the duty GP was to see patients who needed to be seen the same day when the sessions were fully booked. As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received three comment cards and all comments were positive regarding helpfulness of reception staff and standards of care they received.

Spring Gardens Group Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an Expert by Experience.

Background to Spring Gardens Group Medical Practice

Spring Gardens Group Medical Practice provides care for approximately 15,800 patients. There is a high number ethnic minority patients registered including patients who originated from Eastern Europe. The service is located in and covers Worcester City. The practice holds a General Medical Services contract and provides GP services commissioned by NHS England.

The practice is managed by nine GP partners (four males, five females) who between them provide 59 clinical sessions per week. There is a vacancy for a GP who will provide eight sessions per week and senior staff were seeking to fill the vacancy. Those sessions are currently covered by locum GPs who regularly work at the practice who also provide cover for annual leave. GPs are supported by two advanced nurse practitioners, five practice nurses and two health care assistants (HCA). They provide cervical screening, vaccinations, reviews of long term conditions, health checks and phlebotomy (taking blood samples) services. The practice employs a practice manager, a part time acting deputy practice manager, a reception manager, 12 receptionists, six administration staff, a health promotion manager and two secretaries.

The practice offers a range of clinics for chronic disease management, diabetes, heart disease, cervical screening, contraception advice, minor surgery, injections and vaccinations.

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

Appointments vary slightly between GPs but are generally available:

- From 8am until 12pm and from 3pm until 6pm daily.

Extended hours include:

- Appointments available from 7.30am every Tuesday.
- Appointments commence at 9am every Wednesday to allow time for meetings to be held.
- Patients can be seen by GPs and nursing staff between 6.30pm and 8pm every Wednesday.
- Saturday sessions are held between 8am and 11 am on a few Saturdays each year. Reception staff are told about these dates.

The practice accepts medical students for experience and teaching purposes. It also accepts up to two trainee GPs.

The practice has opted out of providing GP services to patients out of hours such as nights and weekends. During these times GP services are provided currently by a service commissioned by NHS Redditch and Bromsgrove Clinical

Detailed findings

Commissioning Group (CCG). When the practice is closed, there is a recorded message giving out of hours' details. The practice leaflet also includes this information and there are leaflets in the waiting area for patients to take away with them.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

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

Before inspecting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 4 May 2016. During our inspection we spoke with a range of staff including three GP partners, one trainee GP, the nurse manager, an advanced nurse practitioner, one practice nurse and one health care assistant (HCA). We also spoke with the practice manager, acting deputy manager, the reception manager and two receptionists. Information was given to us by an Age UK officer and an officer from Worcestershire Carers Association. We spoke with 10 patients and another who was also a carer and two Patient Participation Group (PPG) members who were also registered patients at the practice. PPG's work with practice staff in an effective way that may lead to improved services. We observed how patients were being cared for and talked with family members and reviewed relevant documentation. We reviewed three comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events which were discussed at dedicated quarterly meetings and relevant information from these was cascaded to relevant staff. Lessons were learnt and improvements made to prevent a similar occurrence.
- When there were unintended or unexpected safety incidents, patients received reasonable support, clear information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Safety was monitored using information from a range of sources, including the Medical and Healthcare products Regulatory Agency (MHRA) alerts and the National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave an accurate overview of safety. When necessary the practice used the National Reporting and Learning System (NRLS). This is a means of sharing lessons learned from safety incidents.
- Patient safety alerts were sent to all relevant staff and if necessary actions were taken in accordance with the alerts such as; individual reviews of patients who may have been prescribed a particular medicine. We saw that patient reviews were carried out and prescribing changes where necessary to protect patients from inappropriate treatment.

We reviewed safety records, incident reports patient safety alerts and minutes of meetings where these were discussed. We saw evidence of improved safety arrangements following incidents.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The policies were appropriate and accessible to all staff. They included contact details of external professionals who were responsible for investigating allegations. There was a lead member of staff for safeguarding who had received appropriate training. GPs attended safeguarding meetings when possible and when requested, provided reports for other agencies. Clinical staff kept a register of all patients that they considered to be at risk and regularly reviewed it. All staff had received training that was appropriate to their role. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. A member of staff provided an example of a recent concern and how they dealt with it appropriately. We were also provided with written information about the involvement of a GP in a case of concern.
- A notice was displayed in the waiting room and in each consulting room and the waiting areas, advising patients of their right to have a chaperone. All staff who acted as chaperones had been 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 confirmed that clinical staff offered them this facility. During our inspection we spoke with a member of staff who had been asked by a GP on the same day to act as a chaperone.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. An advanced nurse practitioner/nurse manager was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. Annual hand

Good

Are services safe?

hygiene checks were carried out on all clinical staff to ensure safe practice. The advanced nurse practitioner told us they monitored general hygiene standards and liaised with cleaning staff as required.

- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Blank prescription forms for use in printers were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice did not give hand written prescriptions to patients. One of the GP partners led in safe prescribing and carried out regular checks. A Clinical Commissioning Group employed pharmacist also visited the practice twice a week and carried out audits on GP prescribing.
- We reviewed three personnel files of the latest recruits and found 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 DBS checks. Necessary recruitment and safety checks were carried out before trainee GPs and locum GPs were employed to work at the practice.
- There were systems in place to ensure test results were received for all samples sent for analysis and the practice followed up patients who were referred as a result of abnormal results. All correspondence received at the practice was dealt with on the day it was received.

Monitoring risks to patients

- There were procedures in place for the monitoring and management of risks to patient and staff safety. A health and safety policy was available to all staff. There were up to date fire safety risk assessments, staff carried out regular fire drills and weekly fire alarm testing.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, clinical waste and legionella. (Legionella is a term used for a particular bacteria which can contaminate water systems in buildings.)
- Staff told us the practice was well equipped. We saw records that confirmed equipment was tested and regularly maintained. Medical equipment had been calibrated in accordance with the supplier's instructions. We were shown evidence where equipment ceased working and replacement equipment was promptly ordered.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. All staff absences were covered by other staff re-arranging or working extra shifts. A limited number of Locum GPs were used when GPs were on annual leave to ensure continuity of care was given to patients.

Arrangements to deal with emergencies and major incidents

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- Staff had access to NICE and local guidelines and used this information to deliver care and treatment that met patients' needs. They also kept up to date with current practice by using topics such as patient safety alerts and medicines management. Changes in practice were shared with all clinical staff to ensure consistency in patient care.
- Clinical staff monitored that guidelines were followed through risk assessments, audits and random sample checks of patient records.
- An enhanced service included prevention of unnecessary admissions to hospital. Patients of all unplanned hospital admissions were reviewed within three days of discharge and where necessary care plans put in place to reduce the risk of re-admission. Staff respected patients wishes to remain in their own homes and referred them to the Admissions Prevention Service to support this. We were shown data concerning the gradual downward trend of emergency admissions of patients aged over 75 years. During 2014-15 323 patients aged over 75 years were admitted to hospital as an emergency and during 2015-16 319 were admitted. During 2014-15 11 patients who had asthma were admitted and 7 during 2015-16.
- Clinical staff used a specific tool when carrying out patients' reviews to monitor and improve their use of medicines. This system prevented unnecessary and over prescribing.
- Monthly multidisciplinary meetings were held with palliative care staff, district nurses, social workers, health visitors and members of the Proactive Care Team (PACT). PACT staff were employed by the Clinical Commissioning Group whose objective was to make improvements through general practices. The PACT staff consisted of nurse practitioners and nurses who carried out detailed assessments of 2% of those patients who were most at risk in their own homes or those residing in care homes. The nurse practitioners prescribed medicines, when necessary. PACT staff had access to patients' records to promote streamlined care for those patients.
- GPs held three monthly meetings to discuss all patients who received palliative (end of life) care and deaths that had occurred. District nurses and a palliative care nurse attend the meetings. The care provided was discussed and areas where a different approach could improve outcomes for patients in the future.
- Clinical staff held monthly clinical meetings where various disorders were discussed including care management. Topics included mental health, diabetes, back pain, stress management and cardiology some of which had external speakers. This arrangement ensured that all GPs assessed and treated patients in a uniform way.
- There were 66 patients registered with the practice who had a learning disability. All of these patients had received an annual review. The reviews were carried out by the same nurse and the lead GP to promote patient confidence in the practice. The clinical staff had requested training for their role from the NHS Learning Disability Service (LDS) and this had been provided in March 2014. Staff told us they had maintained contact with the LDS team when they needed further advice about patient care.
- In 2008 the practice commenced carrying out clinical research projects and had completed 23 projects. The results were shared with other practices within Worcestershire to maximise patient care. Benefits included an improved system for controlling high blood pressure resulting in improved patient care. Staff were using an improved smoking cessation system when advising and encouraging patients to stop smoking. Also the practice had implemented exercise classes that improved the lifestyles of patients who have dementia.
- The current research projects were based upon patients who experienced mental health illness. One involved the assessment of cardiovascular risk to these patients. The other research concerned Relatives Education and Coping Toolkit (REACT). It provided on-line peer support and a toolkit for assistance with the aim of reducing the stress levels experienced by relatives.

Good

Are services effective?

(for example, treatment is effective)

- All patients who experience severe mental health illness had care plans in place that were regularly reviewed. Care plans included physical health disorders. These patients were seen by their own GP for continuity of care. These patients were offered same day appointments with GPs to ensure they received a prompt service.
- Sessions were held twice a week at the practice by the Gateway mental health team who provided advice, support and signposting for patients who were experiencing poor mental health.
- Patients who had dementia were investigated and referred to the early intervention service for advice and support. These patients were offered an annual review and data published in January 2016 stated there had been a 97% uptake; staff actively encouraged patients to attend their reviews and patients received text reminders about their booked appointments.
- The practice provided a monitoring and prescribing service for patients who required warfarin medication. Patients who were unable to access the practice had their tests carried out by district nurses who gave the results to practice staff for prescribing.
- The practice had set up a pilot with the local hospital cardiology service. GPs could send an email requesting advice and the agreement was that they would receive a response within three working days. The results of the project had not yet been analysed.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). Comparisons were also made with the local Clinical Commissioning Group (CCG).

The practice had an overall exception reporting of 8%, which was 1% higher than the local Clinical Commissioning Group (CCG) average and 1% higher than the national average. Exception reporting is the exclusion of patients from the list who meet specific criteria. This includes, for example, patients who choose not to engage in screening processes or accept prescribed medicines.

QOF data published in January 2016 showed the practice was performing in line with CCG and national averages;

- The atrial fibrillation (irregular heart beat) review rate was 100% which was the same the CCG and 2% above the national average. The practice exception reporting rate was 5%.
- The mental health review rate was 100% which was 5% above the CCG average and 7% above the national average. The practice exception rating was 9%.
- Performance for asthma related indicators was 100% which was 2% above the CCG average and 3% above the national average. The practice exception reporting rate was 5%.
- Performance for patients with a learning disability was 100% which was the same as the CCG and national averages. There was no exception rate.
- Performance for diabetes related indicators was 100% which was 6% above the CCG average and 11% above the national average. The practice exception rating was 9%.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators were 100% which was 2% above the CCG average and 4% above the national average. The practice exception rating was 4%.
- The percentage of patients with hypertension having regular blood pressure checks was 100% which was the same as the CCG average and 2% above the national average. The practice exception reporting rate was 2%.

The exception rating for depression and cardiovascular disease was 25%. These were in line with the CCG and national averages. In order to attempt an improved patient attendance the results were discussed during the Local Medical Committee (group of medical practices) meetings and patients had been contacted by GPs and nurses.

Clinical audits had been carried out that demonstrated relevant changes had been made that led to improved patient care. They included:

- In April 2016 clinical staff had undertaken an audit of patients who had hypertension following a safety alert to check if their medicines were appropriate. The report indicated that prescribing was appropriate and the audit would be repeated six months later to check that prescribing remained appropriate.

Good

Are services effective?

(for example, treatment is effective)

- Another audit carried out in November 2015 concerned joint steroid injections to monitor the results achieved.All minor surgery had been continually audited to determine if there were any complications following the procedure.
- We were shown other audits the health checks carried out for patients with a learning disability, anticipatory medicines for dying patients, the increased number of home visits and why this had occurred. This was a result of requested visits to a care home.

Effective staffing

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

- The practice had an induction programme for newly appointed staff that was role specific. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff were provided with a handbook at the commencement of employment that provided them with practice information and policies that they could refer to.
- The practice had a training programme in place and extra courses were provided that were relevant to roles. For example, administration of vaccines, the cervical screening procedure and reviews of long term conditions. Staff who administered vaccines could demonstrate how they stayed up to date with changes of the immunisation programmes.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. Staff we spoke with told us they had the opportunity to build on their knowledge and development to enhance services provided to patients. For example, the nurse manager had recently completed training in clinical assessment to enable them to see patients with acute and minor illnesses and prescribe for them. A recently appointed practice nurse was attending university to enhance their knowledge and skills and was able to give patients written directions about their medicines.
- The learning needs of staff were identified through a system of meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. They told us they could ask for additional support at any time. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

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

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. GPs we spoke with understood the Gillick competency test. It was used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions.

Supporting patients to live healthier lives

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

Good

Are services effective?

(for example, treatment is effective)

- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. In the last 30 months 57% of patients had been screened for bowel cancer, the CCG average was 62% and the national average 58%. In the last 36 months 74% of patients had been screened for breast cancer, which was in line with the local and national averages.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records and audits to ensure the practice met its responsibilities with legislation and national guidelines.
- Written consent was obtained before each minor surgery procedure commenced and the recordings included possible complications had been explained to patients.
- These included patients who received palliative (end of life) care, carers of patients, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. All eligible patients who attended the practice had received advice on obesity. Patients were then signposted to relevant services.
- Patients who had complex needs or had been identified as requiring extra time were given longer appointments to ensure they were fully assessed and received appropriate treatment.
- The Health Promotion Managers role was to carry out computer searches and identify patients who had long term conditions who needed a review. They contacted the patients and requested they made an appointment. The details of those patients who did not attend (DNA) for their appointment were passed on to clinical staff. All clinical staff had the responsibility for contacting patients and encouraging them to attend. Reminders were sent by phone and letters.
- All clinical staff including the health care assistants (HCA) provided advice about leading healthy lifestyles and staff had received appropriate training for their role.
- A GP held regular sexual health clinics for routine and emergency contraception.
- Clinical staff visited a traveler's campsite last year to provide information about the practice and health education.
- The Age UK officer worked alongside clinical staff to raise patient awareness about their long term condition in the patient's first language to enable their understanding and need to attend for reviews. They gave patients written information in their language about maintaining a healthy diet.
- Newly registered patients received health checks and their social and work backgrounds were explored to ensure holistic care could be provided. If they were receiving prescribed medicines from elsewhere these were also reviewed to check they were still needed.
- Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94% to 98% and five year olds from 92% to 98%.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and the NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.
- The practice's uptake for the cervical screening programme within the QOF score was 92%, which was 9% above the CCG and 10% above national averages. However the practice exception rating was 20%. We asked a GP and the practice manager why the exception rating was higher than average. They told us that a number of Asian and Eastern European patients repeated declined even though the health benefits were explained to them. The result had been discussed in various meetings across the city but the practice had not found a way of improving patient attendance.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consulting and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff told us they responded when patients wanted to discuss sensitive issues or appeared distressed by offering them a private room to discuss their needs.
- Most of the 11 patients we spoke with and the two PPG members were very complimentary about the way in which all staff communicated with them.
- The three patient comment cards we received were positive about the service they received and about how staff communicated with them.
- Throughout our inspection we observed how staff responded to patients and saw they were treated with respect at all times. We saw that staff were friendly and helpful. Patients told us that staff provided either a good or very good.

Results from the national GP patient survey published in January 2016 showed if patients felt they were treated with compassion, dignity and respect. The results were mixed satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%
- 86% 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%.
- 87% of patients said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 97% of patients said they had confidence and trust in the last nurse they saw or spoke with compared to the CCG average of 98% and national average of 97%.
- 89% of patients said the last nurse they spoke with or saw was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.

We spoke with the practice manager about the lower than average survey results. They told us that they were aware of the results and were looking at ways of making improvements such as; extended telephone lines for patient access.

Care planning and involvement in decisions about care and treatment

We spoke with 11 patients and reviewed three comment cards on the day of our inspection which confirmed that patients felt involved with decisions about their healthcare and treatment. Most patients spoke positively about the way that GPs and nurses explained their condition and the options available to them about their care needs. One patient felt that their health status had not been fully explained to them and that treatment choices had not been offered to them. Another patient felt that they had not been given the correct diagnosis for a condition they felt they had.

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

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.
- 82% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 82%.
- 87% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.

Good

Are services caring?

- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 85%.

The practice was piloting the 'time to talk' (community champions) initiative for local residents. A receptionist had been trained to offer the service. They spent 15 hours per week circulating with patients during busy periods. Their role was to engage, listen and signpost patients to non-medical services such as; carers support, bereavement services, Citizens Advice, Age UK and social workers. Each patient was telephoned after two weeks to ascertain if improvements had been achieved. Data was sent to the CCG who analysed the results and informed the practice of the outcome. The analysis told us that patients had received advice about carers, housing, anxiety, loneliness and practice home help.

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

Staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations including a bereavement service. Following a bereavement a GP offered them support and if necessary referral to a counselling service. Both the Age UK officer and the 'time to talk' receptionist also provided signposting to bereavement support services.

The practice's computer system alerted GPs if a patient was also a carer. There were 317 carers on the register which equated to 2% of registered patients. We spoke with an officer from the Worcestershire Carers Support Services who told us they had a good relationship with the practice and that staff were proactive in identifying carers. They said that they provided telephone advice to GPs and had provided general information and how clinical staff should make referrals. The officer informed us about the range of services and signposting they give to patients. They included prevention of carer's breakdown; housing, emotional expectations when caring for others, how to obtain time off and privacy and what to do if they did not cope with the task. We were told that practice staff had fully embraced the concept of carers and provided them with good support. There was a display stand in the waiting area and information was available on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that practice staff were responsive to patient's needs and had systems in place to maintain the level of service provided. The demands of the practice population were understood and arrangements were in place to address the identified needs of patients. Services such as; diabetic clinics ante natal care and smoking cessation advice were provided at the practice. Services were planned and delivered that took into account the differing needs of patient groups. For example:

- Senior staff were engaging with the Clinical Commissioning Group (CCG) and staff were actively striving to make on-going improvements. CCG's are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. Meetings were held every six months with the CCG to review performance and agree ways of making further improvements to patient care.
- The lead nurse who specialised in care of patients with diabetes recently gave talks to patients of ethnic minorities who first language was not English. An officer from Age UK provided a translation service about healthy diet and the importance of attendance for reviews. This resulted in higher attendances at the practice so consideration was being given to repeating the talks.
- There were sufficient routine appointments available to meet demand and we saw that by lunchtime there was still unfilled morning appointments.
- Patients were offered telephone or face to face consultations.
- Reception staff gave out appointment cards when patients made appointment within the practice and patients received text message reminders.
- Regular meetings took place to discuss and plan care for vulnerable patients and those with complex needs.
- Home visits were available for elderly patients and those who were unable to access the practice.
- Urgent access appointments were available for children and those with serious or complex medical conditions. These patients were seen on the day by the duty GP even if the clinical sessions were fully booked.
- There were longer appointments available for people with a learning disability and patients with other long term conditions.
- Easy read letters and leaflets including how to make a complaint were available for patients who had a learning disability to enable their understanding.
- There were extended hours available to improve patient access.
- There were facilities for patients with a disability, a hearing loop and translation services available.
- Early diagnosis of dementia ensured that clinical staff could put support systems in place to improve their health and well-being.
- Specific health checks were available for patients who experienced poor mental health and support systems for relatives to access to help them with their coping mechanism.
- The GPs visited two care homes to see patients who were registered with the practice. They had provided support to one care home to improve their performance. We contacted the care home and spoke with the manager. They said the practice had provided daily support and the timings of visits were to accommodate the patients. Daily visits were made to Acorns Children's Hospice and weekly visits to the Royal National Institute for the Blind.
- The practice was piloting the 'time to talk' (community champions) initiative for local residents. A receptionist had been trained to offer the service. They spent 15 hours per week during busy periods circulating with patients. Their role was to engage, listen and signpost patients to non-medical services such as; carers support, bereavement services, Citizens Advice, Age UK and social workers. Each patient was telephoned two weeks later to ascertain if improvements had been achieved. Data was sent to the CCG analysed the results and informed the practice of the outcomes. The analysis told us that patients had received advice about carers, housing, anxiety, loneliness and practical home help.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

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

Appointments varied slightly between GPs but were generally available:

- From 8am until 12pm and from 3pm until 6pm daily.

Extended hours included:

- Appointments available from 7.30am every Tuesday.
- Appointments commenced at 9am every Wednesday to allow time for meetings to be held.
- Patients could be seen by GPs and nursing staff between 6.30pm and 8pm every Wednesday.
- Saturday sessions were held between 8am and 11 am on a few Saturdays each year. Reception staff were told about these dates.

All children were seen on the day the appointment was requested. Longer appointments were available for patients who had a learning disability or complex needs. All nurse appointment were 15 minutes compared to 10 minutes for GPs.

Patients were encouraged to use the on-line service for making appointments and requesting repeat prescriptions. To assist them a receptionist spent 15 hours per week speaking with patients and advising them about this service.

The practice manager informed us that they had a number of homeless patients registered with the practice. They were offered prompt appointments because they tended not to attend for pre-booked appointments.

Results from the national GP patient survey published January 2016 showed patients' satisfaction with how they could access care and treatment. The results were mixed in comparison with local and national averages:

- 70% 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%.
- 80% of patients said they were able to get an appointment to see or speak with someone last time they tried compared to the CCG average of 80% and the national average of 76%.
- 71% of patients described their experience of making an appointment as positive compared to the CCG average of 78 and national average of 73%.
- 74% reported they were satisfied with the opening hours compared to the CCG average of 81% and national average of 78%.

In response to the survey the practice had made arrangements to have the number of telephone lines to the practice increased.

Most patients we spoke with on the day of the inspection and comment cards we received told us that they were able to get appointments when they needed them and that they were satisfied with the opening hours.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. Information about how to make a complaint was available on the practice's website, in the practice leaflet and in the waiting area.

- The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.
- The practice kept a complaints log and there had been 13 formal complaints received during 2015.
- We saw that complaints had been dealt with in an effective and timely way. Complaints were discussed with staff to enable them to reflect upon them and any actions taken to reduce the likelihood of future incidents. Complaints were reviewed regularly during staff meetings to ensure that appropriate actions had been taken.
- The practice manager told us they dealt with verbal complaints promptly through discussions with patients.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- Clinical staff met regularly with other practices to share achievements and to make on-going improvements where possible.
- Senior staff had considered the needs of the future and acknowledged that the patient list was steadily increasing. An application had been made to extend the practice and increase the number of consulting rooms.
- Senior staff had identified that further clinical staff would be needed and were trying to recruit another GP.
- The practice was working with the federation group to gain a consistent approach to practice wide on-line patient access.
- The practice manager had worked with the CCG project in the development of care templates for end of life care, chronic obstructive pulmonary disease (COPD) and asthma. They also worked with the CCG lead in the production of an EMIS protocol for the Mental Capacity Act/Deprivation of Liberty Safeguards that was shared with clinicians across the County.
- The practice manager was working with other practices in developing a consistent way of computer flagging patients who were at risk of harm. This would provide an effective system for patients when they moved between practices.

Governance arrangements

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Staff worked as a team and supported each other in achieving good patient care.
- Clear methods of communication that involved the whole staff team and other healthcare professionals disseminated best practice guidelines and other information.
- Staff attended regular team meetings to discuss issues, patient care and further develop the practice.
- Practice specific policies were implemented and were available to all staff.
- Clinical staff had an understanding of the performance of the practice and an action plan had been implemented to improve performance.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

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

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

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

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. It had gathered feedback from patients through the Patient Participation Group (PPG) and through surveys and complaints received. A PPG are a group of patients registered with a practice who work with the practice to improve services and the quality of care. There was an active PPG which met regularly and regularly liaised with

Are services well-led?

Good

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

senior staff between these times. PPG members said they felt that staff listened to them and that changes would be facilitated whenever practicable. For example, the PPG had suggested improvements to the telephone system, completed redecorating and purchase of new chairs for the waiting areas.

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

Continuous improvement

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

The practice manager had worked with the CCG project in the development of care templates for end of life care, chronic obstructive pulmonary disease (COPD) and asthma. They also worked with the CCG lead in the production of an EMIS protocol for the Mental Capacity Act/ Deprivation of Liberty Safeguards that was shared with clinicians across the County.

Development of the Worcestershire Hub (Clinical Contact Centre) (CCC) was well advanced towards implementation and was due to go live on 11 May 2016. This meant that when patients rang for an appointment they were given the option of speaking with an advanced nurse practitioner at the CCC who would listen and give patients advice about their health. If the advanced nurse practitioner felt that an appointment with a GP was needed they had the ability to do this by accessing the practice computer system.