Haresfield House Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
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 Haresfield House Surgery on 19 June 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. The practice recorded information about safety and reviewed, monitored and took any action that was necessary.
- The practice assessed risks to patients and managed these well.
- The GPs and practice nurses assessed patients' needs and planned and delivered care following best practice guidance.
- Staff received training appropriate to their roles and the practice identified and planned any further training needs.
- Patients were positive about the practice and described staff as kind, compassionate and professional. Most patients had good experiences of contacting the practice and obtaining appointments.
- The practice provided information about how to complain which was easy to understand and aimed to use information from complaints positively to help them improve.
- The practice was well equipped to treat patients and meet their needs.
- There was an open and supportive approach to management and staff felt supported by their colleagues and by the partners
- The practice encouraged and valued feedback from patients and had an active patient participation group (PPG) which was positive about their developing relationship with the practice team.

We saw several areas of outstanding practice including:

- The practice designated one GP each morning to carry out all the home visits. They began the visits at the start of the day. This enabled patients to receive

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treatment at home promptly, including any medicines they needed and so decreased the potential for them to need a hospital admission. Requests for hospital admissions which were necessary could be arranged early in the day. Data showed that the practice had fewer unplanned admissions and lower accident and emergency attendance than the national average.

- The practice manager had contributed to the development of a local proactive care team for older people. This involved contributing to work on the design, staffing model, recruitment and implementation of the service.
- One of the practice nurses specialised in diabetes and ran the X-pert Diabetes Programme for patients at the practice. They invited all newly diagnosed patients to attend but the sessions were also open to longstanding patients. This provided information, advice and support for patients and in particular those with a new diagnosis and those needing to establish effective control of their diabetes. The practice aimed to review patients twice a year and the nurse maintained direct telephone contact so patients could contact them easily. The practice held a weekly diabetes clinic with 15 minute appointments and saw approximately 50 patients each month. Newly diagnosed patients had a 45 minute initial appointments. Performance for diabetes related indicators was better than the national average for nine out of 12 indicators we reviewed.
- The practice had hosted an eight week course run by Worcestershire Association of Carers for 40 patients who were carers. This involved providing a room and refreshments as well as identifying patients, funding the cost of sending invitations and co-ordinating the confirmation arrangements.
- One of the practice nurses specialised in leg ulcer care and staffed a local leg ulcer clinic called the Leg Club. The practice funded the nurse's time for this for one afternoon every one to three weeks although initially this was more frequent. This service was for patients of all the practices in the area. The service provided continuity of care and operated on a 'drop-in' basis which provided flexibility for patients in a sociable environment and enabled the nurse to develop her practice and share learning with the practice team.

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

- Maintain records of prescription pads in line with guidance from NHS Protect.
- Include minor surgery in their programme of clinical audits.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. The practice learned when things went wrong and shared this internally and externally to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients, staff and others using the building were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff were aware of guidance from the National Institute for Health and Care Excellence (NICE) and took this into account in the care and treatment they provided. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff received annual appraisals and training appropriate to their roles. The practice supported them to develop their knowledge and skills. Staff worked in partnership with other professionals involved in providing care and treatment to patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of the care and support provided. A consistent theme in their feedback was that the practice team were helpful, understanding and caring. Patients described staff as kind, compassionate and professional. Information for patients about the services available, including for carers, was easy to understand and accessible.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. It was aware of the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to identify local needs. Appointments were available the same day or could be booked up to six weeks ahead. The practice had adopted an innovative approach to matching GP availability and appointments. Extended hours were available to benefit patients unable to attend during the main part of the working day. The practice was well designed to make access

Summary of findings

easy for patients with limited mobility. Information about how to complain was available and easy to understand. The practice received few complaints and responded to issues raised. Learning from complaints was shared with staff.

The practice was involved in a number of schemes and initiatives designed to meet the needs of specific groups of patients. This included providing medical cover to Worcester Intermediate Care Unit and a local care home, running the Diabetes X-Pert Programme, helping to staff a local clinic for patients with leg ulcers and hosting a series of training events for carers.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and the partners were enthusiastic, positive and forward thinking. Staff were supportive of the partners' aims for the future of the practice and considered that they were kept informed of plans and developments. There was an open management style and staff felt supported by their colleagues and by the partners. The practice team took part in internal and external meetings and had policies and procedures to support the effective management of the service. There were systems in place to monitor and improve quality and identify risk. The practice encouraged and acted on feedback from staff and patients. There was an active patient participation group (PPG) which was positive about their future role in supporting the practice.

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 as good for the care of older people. The practice provided positive, personalised care to meet the needs of the older people in its population including those living in a local care home. All patients over 75 had a named GP. We spoke with the manager of a care home who told us the GPs always took their time to sit and speak with patients and provided a very good standard of care. Older patients with significant care needs were on the practice's hospital admissions prevention register and the practice had systems to alert staff to patients with significant health and care needs and those at the end of their life.

A GP was assigned to carry out all the home visits every morning so older patients unable to visit the practice received prompt care. As a result, prescriptions and requests for hospital admissions could be arranged early in the day. The GPs and practice nurses worked with the local specialist older people's team and ensured that those older patients with the most complex care needs had care plans. The practice used the Gold Standard framework in planning the care for patients approaching the end of life.

The practice took part in or was planning a number of services and schemes which benefitted older people. This included working with Worcestershire Association of Carers, Age UK and the practice's patient participation group to provide advice and guidance for patients.

The practice provided a nurse to staff a local leg ulcer clinic and the practice provided medical cover for Worcester Intermediate Care Unit a 20 bed step down unit to facilitate hospital discharge. The practice manager had contributed to the development of the local specialist proactive care team for older people. This involved contributing to work on the design, staffing model, recruitment and implementation of the service.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice nurses had lead roles in supporting patients with long term conditions. The nurses and the GPs visited patients at home if their health or mobility meant they were unable to visit the practice. The practice arranged annual health and medicines reviews and booked one appointment for patients with more than one condition to avoid repeat visits to the practice. The practice worked in partnership with relevant health and care professionals to deliver a coordinated care for those people with the most complex

Summary of findings

needs. The practice was involved in a number of schemes and initiatives designed to meet the needs of specific groups of patients. This included running Diabetes X-Pert Programme, providing a nurse to run a local clinic for patients with leg ulcers and hosting a series of training events for carers run by Worcestershire Association of Carers.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice had systems to identify and follow up children living in circumstances which might place them at risk including monthly meetings with health visitors. Local midwives and health visitors used a room at the practice so pregnant women and families with babies and young children could access all their healthcare in one place. Childhood immunisation rates were higher than the local CCG percentage for all but one of these.Appointments were available outside of school hours.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice offered some services at the practice to reduce the need for patients to be referred to secondary services further from home. Patients could book an appointment on the day they wanted to be seen or up to six weeks in advance.Pre-bookable GP appointments were available from 6.30pm to 7.40pm on Mondays. Appointments with a practice nurse were available between 7.30am and 8am on Monday, Tuesday and Thursday. The practice planned to develop the practice website to improve accessibility for patients using tablet computers and mobile phones.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had a lead GP for substance misuse who worked in partnership with a specialist support worker who was based at the practice. Information was available for patients who might need support and guidance due to domestic abuse.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and

how to contact relevant agencies in normal working hours and out of hours. The practice had a process which made sure patients were seen promptly if they appeared vulnerable or at risk when they arrived at the practice.

People experiencing poor mental health (including people with dementia)

Good

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

The practice worked in partnership with local mental health service professionals who used a room at the practice to see patients. They were proactive in encouraging patients to attend for annual reviews. The GPs visited patients at home if the impact of their mental health made visiting the practice particularly challenging. During 2013/14 the practice had completed care plans for a high proportion of its patients experiencing poor mental health (96% compared with the national average of 86.04%) and was proactive in monitoring their smoking and alcohol status in addition to their general health. The practice gave patients information about various support groups and voluntary organisations.

The practice had however only provided a face to face review for 76.6% of patients diagnosed with dementia during 2013/14 compared with the national average of 83.3%. The practice provided data showing this had increased to 79% during 2014/15 and continued to explore ways to ensure more patients living with dementia received annual reviews. The GPs and nurses understood the importance of considering patients ability to consent to care and treatment and dealt with this in accordance with the requirements of the Mental Capacity Act 2005. The practice had arranged dementia awareness training for staff.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 23 Care Quality Commission (CQC) comment cards completed by patients. During the inspection we spoke with a representative from the patient participation group (PPG), a group of patients registered with a practice who worked with the practice team to improve services and the quality of care. We spoke with another by telephone after the inspection. We also looked at the January 2015 national GP patient survey results and comments from 13 recent NHS Friends and Family Test forms shown to us by the practice.

Examples of the practice's national GP patient survey results showed that -

- 79.8% find it easy to get through to this surgery by phone compared with a CCG average of 73.9% and a national average of 71.8%.
- 89.9% find the receptionists at this surgery helpful compared with a CCG average of 88.7% and a national average of 86.9%
- 53.1% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 55% and a national average of 53.5%.
- 88.8% of patients were able to get an appointment or speak with someone the last time they tried compared with the CCG average of 90.4% and the national average of 85.4%.
- 80.9% patients described their experience of making an appointment as good compared with the CCG average of 78.1% and national average of 73.8%.
- 66.1% patients said they usually waited 15 minutes or less after their appointment time compared with the CCG average of 65.1% and national average of 65.2%.

The comments from patients in the 23 CQC comment cards and the Friends and Family comments were almost all positive about the standard of the service provided by the practice. Many patients had taken the time to give us detailed information about the care and treatment they had experienced. A consistent theme in their feedback was that the practice team were helpful, understanding and caring. Patients described staff as kind, compassionate and professional.

Areas for improvement

Action the service SHOULD take to improve

- Maintain records of prescription pads in line with guidance from NHS Protect.
- Include minor surgery in their programme of clinical audits.

Outstanding practice

- The practice designated one GP each morning to carry out all the home visits. They began the visits at the start of the day. This enabled patients to receive treatment at home promptly, including any medicines they needed and so decreased the potential for them to need a hospital admission. Requests for hospital admissions which were necessary could be arranged early in the day. Data showed that the practice had fewer unplanned admissions and lower accident and emergency attendance than the national average.
- The practice manager had contributed to the development of a local proactive care team for older people. This involved contributing to work on the design, staffing model, recruitment and implementation of the service.
- One of the practice nurses specialised in diabetes and ran the X-pert Diabetes Programme for patients at the practice. They invited all newly diagnosed patients to attend but the sessions were also open to longstanding patients. This provided information, advice and support for patients and in particular those

with a new diagnosis and those needing to establish effective control of their diabetes. The practice aimed to review patients twice a year and the nurse maintained direct telephone contact so patients could contact them easily. The practice held a weekly diabetes clinic with 15 minute appointments and saw approximately 50 patients each month. Newly diagnosed patients had a 45 minute initial appointments. Performance for diabetes related indicators was better than the national average for nine out of 12 indicators we reviewed.

- The practice had hosted an eight week course run by Worcestershire Association of Carers for 40 patients who were carers. This involved providing a room and refreshments as well as identifying patients, funding the cost of sending invitations and co-ordinating the confirmation arrangements.
- One of the practice nurses specialised in leg ulcer care and staffed a local leg ulcer clinic called the Leg Club. The practice funded the nurse's time for this for one afternoon every one to three weeks although initially this was more frequent. This service was for patients of all the practices in the area. The service provided continuity of care and operated on a 'drop-in' basis which provided flexibility for patients in a sociable environment and enabled the nurse to develop her practice and share learning with the practice team.

Haresfield House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor, a pharmacy inspector and a second CQC inspector.

Background to Haresfield House Surgery

Haresfield House Surgery is in on the edge of Worcester city. The practice has a branch surgery in Kempsey and so has a mixed city and rural catchment area with low levels of deprivation. It has around 14,230 patients who live mainly in Worcester and the surrounding rural areas. The practice provides primary medical care to people living in one care home. The practice has on site car parking with spaces for patients with disabilities nearest to the entrance. The main surgery is in purpose built premises in a building which also accommodates another GP practice.

The practice is open between Monday to Friday and its core hours are 8am to 6.30pm. Core appointment times to see a GP are 8.10am to 11.30am, 2pm to 3.30pm and 3.30pm to 5.45pm. Core appointment times to see a nurse are 8.30am to 1pm, 2pm to 3pm and 3.30pm to 5.30pm. Pre-bookable GP appointments are available from 6.30pm to 7.40pm on Mondays. Appointments with one of the practice nurses are available between 7.30am and 8am on from Monday, Tuesday and Thursday. A drop in system was available after morning surgery and before afternoon surgery when patients could wait to be seen without an appointment.

Online booking and telephone consultations were also available. The practice website provides a chart showing patients which days each of the GPs is on duty and whether this is at the main or branch surgery.

The practice has seven GP partners and three salaried GPs, a physician associate, four practice nurses and three health care assistants. There is a mix of male and female GPs to provide patients with a choice about the gender of the GP they see. The clinical team are supported by a practice manager and an established team of administrative staff and receptionists. The practice is a dispensing practice with a dispensary at the Kempsey branch surgery which has a team of dispensary staff. Following the inspection the practice appointed two part time pharmacists and had plans to recruit additional clinical staff.

The practice provides a range of minor surgical procedures.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

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

Haresfield House is a training practice providing up to two GP training places. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. The practice is also a teaching practice and provides placements for medical students who have not yet qualified as doctors.

The practice does not provide out of hours services. Information for general out of hours cover was provided for

patients. This service is provided by the Worcestershire GP Out of Hours Service operated by Care UK a national organisation. The service is accessed by using the NHS 111 out of hours number.

Why we carried out this inspection

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

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

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 the inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 June 2015. During our inspection we spoke with a variety of staff including GPs, practice nurses, the practice manager and members of the dispensary, reception and administration teams. We visited the branch surgery as well as the main practice. The inspection at the branch surgery focussed on the dispensary.

During the inspection we spoke with a representative from the patient participation group (PPG), a group of patients registered with a practice who worked with the practice team to improve services and the quality of care. We spoke with another on the telephone following the inspection and to the manager of a local care home. We reviewed 23 CQC comment cards completed by patients and carers to provide information about their views and experiences of the service and looked at 13 recent NHS Friends and Family Test forms shown to us by the practice.

Good

Are services safe?

Our findings

Safe track record and learning

The practice had systems for reporting and recording significant events. Staff were familiar with practice procedures for this and where they would find the information they needed. They understood the importance of reporting and recording incidents and knew how to do this. Staff described how the practice tailored responses to significant events based on the level of risk. For example, urgent or serious situations were dealt with immediately. The practice nurses discussed any nursing related significant events at their weekly nurse meetings. The practice had clinical governance meetings every four to six weeks when all significant events were reviewed and discussed so staff could learn from these. We saw evidence that the practice informed patients if a significant event or safety alert affected them. Staff gave us an example of a patient being told the same day that they had been given the incorrect vaccine.

The practice monitored safety using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. The practice had a system for recording all national patient safety alerts received through the Central Alerting System (CAS).This ensured staff were aware of and could act on known safety concerns. The practice used the National Reporting and Learning System (NRLS) to report patient safety incidents. Staff told us that the GPs presented new NICE guidance to each other and the rest of the team at the clinical governance meetings.

We noted that in some cases the amount of detail recorded about learning from significant events was brief. In addition, significant event discussions did not always involve the whole team, just those directly involved in an issue. This could limit learning across the whole team.

Overview of safety systems and processes

The practice had processes to safeguard adults and children from abuse. These reflected relevant legislation and local requirements and were available for all staff on the practice computer system. Safeguarding information, including relevant contact details was also available. Two of the GPs took lead roles for safeguarding and staff knew who they were. Staff understood their responsibilities and had completed training about safeguarding relevant to their role. The practice met monthly with the health visitor to discuss any concerns about children. Staff described examples of situations where they had identified and escalated concerns about the wellbeing or safety of children and adults.

Information was available in the practice to inform patients that chaperones were available if desired or needed. Staff who acted as chaperones were trained for the role. The practice completed comprehensive risk assessments to identify which staff would have unsupervised patient contact and therefore require a disclosure and barring service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice had procedures for monitoring and managing risks to patient and staff safety including records for monitoring maintenance and servicing. There was a health and safety policy, an up to date fire risk assessment and evidence of regular maintenance including fire safety checks. Staff told us the practice carried out two fire drills each year. The practice had a comprehensive health and safety risk assessment covering the whole building.

Portable electrical appliances were tested every year by an electrical contractor. A specialist company spent three days at the practice each year to calibrate and maintain clinical equipment to make sure it worked correctly. The practice had an in house maintenance team and a clear system for staff to record any issues or faults that needed to be dealt with.

The building where the practice was situated also contained another GP practice. This other practice was responsible for precautions against legionella, bacteria which can contaminate water and air conditioning systems. They provided Haresfield House Surgery with copies of six monthly certificates from a specialist company regarding water safety.

The practice premises and equipment were visibly clean and tidy. Specific measures were in place for elements of infection prevention and control such as the use of single use instruments, staff immunisations, spillages and cleaning of privacy curtains. The practice had a lead nurse for infection prevention and control (IPC) and they completed twice yearly IPC audits and attended regular

updates with the IPC lead nurse from the clinical commissioning group. This specialist nurse came to the practice to provide training periodically. All the health care assistants completed annual IPC training.

The practice was a dispensing practice with a dispensary at the branch practice. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We found medicines at both sites were stored securely and were only accessible to authorised staff. Medicines requiring cold storage were stored securely in a locked refrigerator. We saw that staff kept daily temperature records which showed safe temperature ranges for medicine and vaccine storage.

Medicines were purchased from approved suppliers and the dispensary maintained an electronic list of the quantities of medicines in stock. Staff showed us their stock rotation system and records which ensured medicines were in date. Expired and unwanted medicines were disposed of in line with waste regulations. Dispensing errors were recorded and systems were in place to action any medicine recalls. We saw evidence that information about errors was used to make changes to reduce the risk of future errors. We found an open and transparent culture of reporting errors and making improvements to protect patients from harm.

We were told that the practice policy was for dispensed prescriptions to be double checked by two dispensary staff to reduce the risk of errors. However, staff said this did not always happen due to the lack of availability of trained dispensary staff. The practice manager told us the practice was aware of this and dealing with this as a high priority. They subsequently informed us they had appointed two new full time dispensers.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the dispensary staff. These medicines were stored securely and access to them was restricted. The total quantities held were documented in a controlled drugs register which we checked and found was accurate. The dispensary staff said they carried out regular audits of controlled drugs, however there was no record of these extra audits. There were suitable arrangements in place for the destruction of controlled drugs.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. At the branch surgery we saw that changes made to patients' medicines, for example following a hospital discharge, were authorised by a GP. At the main surgery the task of updating patient records was undertaken by a prescription administrator at the surgery. There was no system to ensure that the updated records were checked for accuracy by a GP. Following the inspection the practice appointed two part time pharmacists. The practice manager confirmed that part of their role was to review medicines changes for all patients discharged from hospitals and so their systems for this had been strengthened.

Blank prescription forms were stored securely but the practice did not keep records of the serial numbers or who the prescription pads were issued to in line with national guidance. If a prescription pad was lost it would not be possible to track it.

We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence. We were told that dispensary staff were able to contact a local community pharmacist for any advice or specialist knowledge on medicines. The appointment of two part time pharmacists following the inspection meant that this support was also available in house.

The practice carried out recruitment checks in line with legal requirements and good practice. This included proof of identity, evidence of conduct in previous health and care related roles (where required by legislation), information about qualifications, registration with the appropriate professional body and DBS checks. The practice obtained DBS checks for staff who had direct patient contact including reception staff who acted as chaperones and might have unsupervised contact and staff who supported clinicians during the weekly baby clinic. The practice had a policy and risk assessment regarding this in addition to their recruitment policy. The practice also checked the appropriate information regarding locums used to cover staff absence. Information regarding these checks was split

Good

Are services safe?

between recruitment files and a working file for staff booking locums. Following the inspection the practice confirmed that they had consolidated these to ensure records were complete.

Arrangements to deal with emergencies and major incidents

Staff completed annual basic life support training and emergency medicines and a first aid kit were available. The practice had a defibrillator and oxygen with adult and children's masks and staff were trained to use these. Emergency medicines and equipment were easily accessible to staff in a secure area of the practice and staff knew where they were. All the medicines we checked were in date. The practice computer system included an instant messaging system and each room had an emergency call bell on the wall which staff could use to alert the rest of the team about any emergency.

The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. The plan was available to all staff. All the GPs and practice management team held copies off site and if a major incident took place would cascade the information to other members of the practice team.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems, including clinical governance meetings, to ensure this information was shared with all clinical staff so they were kept up to date.

The practice had fewer patient accident and emergency attendances and emergency inpatients referrals than the national average. Data for October 2013 to December 2014 showed an emergency admissions figure of 7.6% of the number of patients registered compared with the national figure of 8.9%. During 2014 their accident and emergency attendance figures were 25.8% compared with 32.8% nationally. Admissions for a group of 19 specified conditions between October 2013 and September 2014 were also lower than the national average (12.7% compared with 15.7%).

The practice was aware that their prevalence for chronic obstructive airways disease (COPD – the term for a range of lung conditions) was lower than expected and planned to review this to establish whether this was an accurate.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice also took part in the Clinical Commissioning Group (CCG) 'Improving Quality and Supporting Practices' (IQSP) initiative.

The practice's QOF results for 2013/14 showed that the practice had achieved 95.9% of the available points. This was 1.7% above the national average. We noted that –

- Performance for diabetes related indicators was better than the national average for nine out of 12 indicators we reviewed. They had achieved 100.8 out of 107 available points and had low exception reporting.
- Performance for treating patients who had atrial fibrillation with appropriate medicines was in line with the national average (practice 98.15%; national 98.32%)
- Performance for providing patients experiencing poor mental health with an agreed care plan was above the national average (practice 96%; national 86.04%)
- Performance for treating patients with high blood pressure was lower than the national average (practice 79.43%; national 83.11%). The practice had identified this as an area for improvement and provided data showing that this had increased to 83% during 2014/15.
- Performance for annual reviews of patients with a diagnosis of dementia was lower than the national average (practice 76.67%; national 83.82%). The practice provided data showing this had increased to 79% during 2014/15 and were exploring ways to improve this further. The May 2015 IQSP report noted that the practice found some patients reluctant to consider early intervention in relation to their dementia.
- Performance for appropriate treatment of patients who had had fragility fractures with a bone sparing agent was below the national average (practice 70.46%; national 81.27%). The practice provided data showing this had increased to 83% during 2014/15. We saw the report for the practice's May 2015 IQSP visit which confirmed that the practice had put in place a fragility fracture review system.

The practice's prescribing of a specific group of antibiotics which should not be over prescribed was better than the national average during the period 1 January 2014 to 31 December 2014 (3.86% compared with 5.33%). Prescribing of certain non-steroidal anti-inflammatory medicines which should be prescribed with caution was in line with the national average during the same period (75.63% compared with 75.13%).

The practice had recently changed the arrangements for review appointments for patients with long term conditions. They were arranging reviews for those patients based on the month of their birth and if the patient had more than one condition all of these were reviewed at the same time. Staff also told us that when they saw a patient for one thing they always checked their notes in case they were due for a routine review to save them an additional visit to the practice. The practice were confident that this

Good

Are services effective?

(for example, treatment is effective)

would result in significantly higher QOF performance scores for 2014/15 and beyond. We noted that the practice's May 2015 IQSP report noted an improvement in achievement over the past three years.

Clinical audits are a process by which practices can demonstrate ongoing quality improvement and effective care. The practice showed us examples of a number of completed clinical audit cycles. One of these looked at patients identified with impaired glucose tolerance (also known as pre-diabetes) which resulted in the practice developing a new procedure for managing these patients and a new leaflet. These were shared with other practices. Other audits we saw included one in respect of patients with high blood pressure which had been peer reviewed as part of the local CCG's 'Improving Quality and Supporting Practices'(IQSP) initiative. One GP showed us an audit relating to Ear, Nose and Throat referrals and one on patients referred to specialist eye services. These were also carried out in relation to the IQSP initiative and provided evidence of changes made as a result of the audits.

Although the practice provided a minor surgery service they did not have a minor surgery clinical audit. We also saw a practice audit review folder covering 2013 to 2015. This contained 11 clinical audits. We highlighted to the practice that the depth of information and attention to detail in the audits varied, two of these did not state the full date they were done and five did not identify which GP was responsible for the work. Following the inspection the practice told us that they discussed this in clinical governance meetings and were developing a more structured and planned approach to their future clinical audit programme.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment and were encouraged and supported by the practice to complete training relevant to their roles. Training was available through e-learning and in house or external training sessions. Staff told us that the practice had a very positive ethos in respect of staff training and development. One nurse explained that as long as training was relevant the practice supported staff financially, including the cost of travel. We saw evidence that the practice had role specific induction programmes. The practice intended to employ a pharmacist and was in the process of re-advertising for this post. They had already employed a physician associate to broaden the skill mix in the clinical team to increase the number of available appointments.

One of the practice nurses had a master's degree in the care and treatment of patients needing anticoagulant therapy and was a trainer in respect of this subject. They also specialised in respiratory care. Another nurse was a diabetes specialist and ran the X-Pert Diabetes Programme at the practice and one specialised in leg ulcer care. They told us they were encouraged to maintain their training and skills. Three of the practice nurses were clinical nurse supervisors. One of these nurses completed the appraisals for the rest of the practice nurse and healthcare team while they received their clinical supervision from one of the GPs. Non- clinical staff also received annual appraisals carried out by the practice manager. Staff we spoke with were clear about the scope of their roles and responsibilities. There was a structured process for dealing with staff performance concerns which the practice was in the process of reviewing.

The GPs took part in required annual external appraisals to enable them to fulfil their revalidated requirements. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council (GMC) can the GP continue to practice and remain on the performers list with the NHS England.

Coordinating patient care and information sharing

The information staff needed to plan and deliver care and treatment was available to them through the practice's patient record system and the practice computer system. This included all essential information about individual patients' care and treatment including test results and alerts to highlight patients with specific needs. The practice had systems to make sure that important information such as test results was checked and dealt with promptly. The medical secretaries told us told us the practice expected all referral letters for suspected cancer to be sent out on the day the patient was seen by their GP and that the GPs monitored this.

The practice had systems for sharing information about patent care with the out of hours GP service and the

Good

Are services effective?

(for example, treatment is effective)

ambulance service. We saw evidence that the GPs worked in partnership with other professionals including mental health professionals, local community teams, health visitors and specialist palliative care staff.

The practice took its responsibilities regarding protecting personal information seriously and all computer information was backed up every day. The practice team was supported by a computer specialist to ensure this operated smoothly and effectively.

Consent to care and treatment

The GPs and nurses understood the importance of gaining informed consent and were familiar with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff told us that the MCA was covered as part of the safeguarding training they had completed.

The GPs and nurses understood the need to consider Gillick competence when providing care and treatment to young people under 16. The Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We saw evidence of verbal consent recorded and correctly coded in patients' notes.

Health promotion and prevention

The practice used alerts on the computer system to ensure all staff were aware of patients in need of extra support due to their physical or mental health needs or their individual circumstances. This included an unplanned admissions register where patients known to be at risk of rapid deterioration in their health.

The practice provided these patients with guidance about diet, smoking and alcohol cessation as part of reviewing their overall health needs. For example, they had checked the alcohol consumption of 96.23% of patients experiencing poor mental health compared with the national average of 88.65%.

Based on the 2013/14 QOF information the practice's uptake for the cervical screening programme was 84.56%, compared with the national average of 81.88%.

Baby clinics were held every week but families could also book appointments on other days if they needed to. The GPs carried out checks on new babies at six weeks and the practice nurses carried out childhood immunisations. Childhood immunisation rates were higher than the local CCG percentage for all but one of the standard childhood vaccinations.

The practice encouraged patients to have annual flu vaccinations and national data showed that the 72.74% of eligible patients over 65 years had received this compared with the national average of 73.24%. The figures for patients under 65 in at risk groups were 49.53% compared with the national average of 52.29%. The practice's May 2015 IQSP report identified that the practice were looking at ways to encourage patient take up of vaccines for the next flu vaccination programme.

The practice provided a range of health checks. These included new patient health checks and cervical screening. The practice provided shingles vaccinations for patients aged 70 and 79 and meningitis C vaccinations for students.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

All 23 CQC comment cards completed by patients contained complimentary information about the practice. Patients used words such as considerate, compassionate, friendly, helpful and understanding to describe staff and the service they received. They confirmed that they were treated with dignity and respect. Some patients provided examples of their care and treatment during periods of poor health and praised the practice for the support they provided.

Results from the national GP patient survey in January 2015 showed patients were happy with how staff at the practice treated them. The practice had average or slightly above average scores for satisfaction with consultations with doctors and nurses and other aspects of the service. For example:

- 91.1% said the GP was good at listening to them compared with the CCG average of 90.2% and national average of 87.2%.
- 89.3% said the GP gave them enough time compared with the CCG average of 88.2% and national average of 85.3%.
- 94.5% said they had confidence and trust in the last GP they saw compared with the CCG average of 93.8% and national average of 92.2%
- 86.6% said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 86.7% and national average of 82.7%.
- 78.5% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80.9% and national average of 78%.
- 89.9% said they found the receptionists at the practice helpful compared with the CCG average of 88.7% and national average of 86.9%.

The practice showed us 13 recently completed NHS Friends and Family comment cards which also reflected a positive picture of the service. We spoke with a member of the patient participation group (PPG) during the inspection and with another by telephone. They spoke positively about the practice being caring, concerned and helpful.

The practice provided curtains around treatment couches so that patients' privacy and dignity was maintained during examinations. We saw that staff closed the doors to consultation and treatment room during consultations. During the inspection we did not find that we could overhear conversation in these rooms however, the PPG identified this as a concern at the branch surgery. The practice explained that this had occurred when a second door leading to treatment rooms was not kept shut. They had reminded GPs to check both doors were closed and had put a poster on the door to ask patients to close it behind them.

Care planning and involvement in decisions about care and treatment

Patient feedback on comment cards we received and Friends and Family cards shown to us by the practice was positive. Some patients specifically commented that GPs explained things to them and kept them informed. The PPG member we spoke with told us that the GPs dealt with patients with care and concern, wanted to get to the bottom of people's conditions and did not hurry them. This sometimes resulted in GPs running late they told us but most patients took the view that it might be them needing the time on another occasion.

Results from the national GP patient survey published in July 2015 for patients' responses to questions about their involvement in planning and making decisions about their care and treatment were in line with local and national averages. For example:

- 87.1% said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 88.2% and national average of 85.3%.
- 81.3% said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 77.9% and national average of 74.6%
- 73.5% said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 79.6% and national average of 76.7%.
- 69.5% said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 67.7% and national average of 66.2%

Staff told us that interpreting services were available for patients who did not speak English as their first language although they rarely needed to use this. British Sign Language interpreters were also available when needed for people who used this.

Good

Are services caring?

We spoke with the manager of a local care home where some of the practice's patients lived. They told us that the GPs took their time to sit and speak to patients when they visited and that the care delivered by the GPs was second to none.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room directed patients to a number of local and national carers' organisations. The practice worked closely with the local hospice and had leaflets regarding bereavement services in the waiting areas. Staff we spoke with in the practice recognised the importance of being sensitive to patient's wishes. The practice used the Gold Standard Framework for end of life care and the manager of a local care home confirmed that the GPs were sensitive to the needs of patients and their carers.

The practice had a register of patients who were carers to help ensure they were identified and offered support. The practice had leaflets in the reception area for Worcestershire Association of Carers. These contained information about emergency carers' cards, telephone support, legal and financial advice and moving and handling training. The leaflet also included a form that patients could use to register with the association.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Before the inspection we obtained information from the NHS England Area Team and South Worcestershire Clinical Commissioning Group (CCG). This provided a picture of GPs who engaged positively with these organisations so that they had a good understanding of the wider picture of health provision in the local area. One of the practice GP partners was actively involved with the CCG.

The practice planned and delivered its services to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. Some of the services they provided or contributed to were particularly positive, for example:

- The practice provided medical cover for Worcester Intermediate Care Unit a 20 bed step down unit to facilitate hospital discharge and reduce the risk of re-admission. This involved a daily ward round on weekdays, weekly multi-disciplinary team meetings, liaison with patients' families and responsibility for discharge notes when patients leave the unit.
- The practice designated one GP each morning to carry out all the home visits. They began the visits at the start of the day. This enabled patients to receive treatment at home promptly, including any medicines they needed and so decreased the potential for them to need a hospital admission. Requests for hospital admissions which were necessary could be arranged early in the day. Data showed that the practice had fewer unplanned admissions and lower accident and emergency attendance than the national average.
- One of the practice nurses specialised in leg ulcer care and staffed a local leg ulcer clinic called the Leg Club. The practice funded the nurse's time for this for one afternoon every one to three weeks although initially this was more frequent. This service was for patients of all the practices in the area. The service provided continuity of care and operated on a 'drop-in' basis which provided flexibility for patients in a sociable environment and enabled the nurse to develop her practice and share learning with the practice team.
- One of the practice nurses specialised in diabetes and reviewed all patients twice a year. They ran the X-pert Diabetes Programme for patients at the practice and ran regular six week courses of two and a half hour education sessions for patients. They invited all newly diagnosed patients to attend but the sessions were also open to longstanding patients. They told us these were particularly valuable for patients finding it challenging to come to terms with their diagnosis or establish effective control of their diabetes. The nurse told us they worked hard to make sure all patients attended for their reviews and maintained direct telephone contact so patients could contact them easily. They told us they had 67 patients with Type 1 diabetes and provided insulin initiation. They and one of the GPs held a weekly diabetes clinic with 15 minute appointments and saw approximately 50 patients each month. Newly diagnosed patients had a 45 minute initial appointments. The practice nurse told us they used this to provide information about diabetes, including showing a video, and to provide time for patients to ask questions.
- The practice had hosted an eight week course run by Worcestershire Association of Carers for 40 patients who were carers. This involved providing a room and refreshments as well as identifying patients, funding the cost of sending invitations and co-ordinating the confirmation arrangements.
- The practice manager had contributed to the development of a local proactive care team for older people. This involved contributing to work on the design, staffing model, recruitment and implementation of the service.

Other ways the practice responded to patients' needs included:

- The premises and services had been designed to meet the needs of people with disabilities including designated parking spaces, accessible toilets, a passenger lift and adequate space for wheelchairs.
- There were baby changing facilities and space for prams and pushchairs.
- Staff completed e-learning about equality and diversity to assist them to understand the varied needs that patients might have.
- A portable hearing loop was available for use by patients who used hearing aids and a poster to inform patients they could ask to use it. Patients who found it difficult to communicate by telephone could fax appointments requests to the practice and received a

fax confirmation. Several reception staff had been on a deaf awareness course and one had completed a stage one British Sign Language course for their own interest which they were able to use at work.
- Leaflets were available in large print format for people with sight difficulties.
- The GPs and nurses made home visits to patients whose health or mobility prevented them from going to the practice for appointments. This included patients experiencing poor mental health.
- Staff had access to translation and interpreter services if a patient needed these. Patients who needed these had an alert in their records so reception staff knew to arrange this for the patient's appointment.
- There were male and female GPs to give patients a choice about the gender of the GP they saw.
- A GP visited a local care home every week to maintain oversight of patient care and build relationships with patients and staff. The GPs and nurses also visited as and when this was necessary.
- One of the GPs was the practice's lead for substance misuse. They arranged all the prescriptions for those patients and worked in partnership with a specialist support worker based at the surgery.

Access to the service

The practice was open between Monday to Friday and its core hours were 8am to 6.30pm. Core appointment times to see a GP were –

- 8.10am to 11.30am
- 2pm to 3.30pm
- 3.30pm to 5.45pm

Core appointment times to see a nurse were –

- 8.30am to 1pm
- 2pm to 3pm
- 3.30pm to 5.30pm.

Pre-bookable GP appointments were available from 6.30pm to 7.40pm on Mondays. Appointments with one of the practice nurses were available between 7.30am and 8am on Monday, Tuesday and Thursday.

The practice website provided information about when each GP was at the practice (or at the branch surgery) to assist patients who wanted to make appointments with a preferred GP. The branch surgery was open every weekday from 8.15am to 12 pm and from 3pm to 6pm on Monday, Wednesday and Friday.

A same day overflow system was available after morning surgery and before afternoon surgery when patients could wait to be seen. The practice placed no maximum limit on the numbers of patients for this. Online booking and telephone consultations were also available.

Patients could book an appointment on the day they wanted to be seen and the practice prioritised children and patients needing to be seen urgently. Routine appointments could be booked up to six weeks ahead.

The practice had developed an effective and well organised system to help them manage GP availability and appointments in a planned way. This involved carefully managing GP annual leave and colour coding each week according to expected staffing levels. This enabled the practice to plan the availability of appointments in advance. For example, if most GPs were working, that week would be coded 'green' but if capacity would be reduced due to planned leave it was coded 'red'. Reception staff knew to book advance non-urgent appointments in 'green' weeks to increase capacity for urgent appointments during 'red' and 'amber' weeks when fewer GPs were available.

Results from the January 2015 national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mostly better than local and national averages. For example:

- 80.5% of patients were satisfied with the practice's opening hours compared with the CCG average of 75.7% and national average of 75.7%.
- 79.8% patients said they could get through easily to the surgery by telephone compared with the CCG average of 73.9% and national average of 71.8%.
- 80.9% patients described their experience of making an appointment as good compared with the CCG average of 78.1% and national average of 73.8%.
- 66.1% patients said they usually waited 15 minutes or less after their appointment time compared with the CCG average of 65.1% and national average of 65.2%.
- 88.8% of patients were able to get an appointment or speak with someone the last time they tried compared with the CCG average of 90.4% and the national average of 85.4%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 53.1% of patients with a preferred GP were usually able to see or speak with that GP compared with the CCG average of 55% and the national average of 53.5%.

This was also demonstrated in the CQC comment cards and the NHS Friends and Family comments provided by the practice.

The practice had worked to reduce the number of appointments missed by patients by contacting them to find out why they had not kept their appointment. This had improved attendance and the practice had identified that the number of missed appointments had fallen from 350 a month in April 2014 to 90 in August 2014.

Listening and learning from concerns and complaints

The practice had a process for handling complaints and concerns. This was in line with recognised guidance and contractual obligations for GPs in England. There was a designated member of the team with responsibility for complaints handling.

There was information on the waiting room noticeboards explaining the complaints procedure. There were also complaints and compliments leaflets available. The leaflets provided patients with the names and contact details of the practice manager and informed patients that if they did not wish to contact the practice directly they could complain to NHS England. Details of Healthwatch and the Parliamentary and Health Service Ombudsman (PHSO) were also provided in the leaflet.

We looked at five complaints received in the last 12 months and found these were dealt with well. The practice had responded in a timely manner and the responses were written in a caring tone. In some circumstances the practice met patients to discuss their concerns face to face. We saw evidence that the practice used complaints to make improvements at the practice. For example as a result of one complaint regarding parental responsibilities the practice devised a well written letter highlighting the law in this area. A copy of this letter was shared at the clinical governance meeting where all complaints were discussed.

The practice audited complaints and discussed these at practice meetings and carried out an annual review. Any verbal complaints that required further action were dealt with in the same way and also recorded for reference and learning. We highlighted to the practice that in some cases the notes about the learning for the practice did not provide an effective audit trail.

One of the complaints we reviewed was referred to the PHSO. They did not uphold the complaint and were positive about how the practice's handling of complaints.

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 partners recognised the importance of strategic planning and the role of the practice in meeting the needs of the practice population into the future. They recognised the need for general practice to change and for practices to be forward thinking. The partners and practice manager held six monthly business planning meetings to consider the challenges they faced and how to address these. They had also discussed issues such as reduced funding (due to a change from a PMS to GMS contract) with the patient participation group (PPG). A PPG is a group of patients registered with a practice who worked with the practice team to improve services and the quality of care.

The practice had identified a number of areas for development. These included developing aspects of clinical care such as the management of blood pressure and certain long term conditions and enhancing their capacity to respond to acute health needs by having a more diverse skill mix in the staff team.

All of the practice staff we met were supportive of the partners and enthusiastic about supporting them in developing the practice. They told us that the GPs and practice manager kept them informed about any changes or future plans for the practice.

Governance arrangements

The practice had a framework to support the management and delivery of the service. This included:

- A clear staffing structure with named staff responsible for designated areas of management and practice.
- Practice specific policies which were available to all staff.
- Structured processes to monitor safety including the maintenance of equipment.
- Engagement with the local Clinical Commissioning Group (CCG) 'Improving Quality and Supporting Practices' initiative.
- Involvement in internal and external audit, including clinical audits to monitor quality and identify areas for improvement.
- Protected time on one afternoon every week for each GP partner to manage aspects of their work which did not involve face to face patient contact. This included clinical and patient care related administrative tasks such as referral letters, test results and clinical audit.

Leadership, openness and transparency

The partners had the experience and ability to run the practice and provide high quality care. The partners described positive working relationships with each other and valued the loyalty and commitment of the staff team. Practice staff told us they enjoyed working there and confirmed that they felt well supported by the partners and management team. The practice nurse team was experienced and took lead roles in areas where they had specific areas of knowledge and skills.

The practice held a wide range of meetings to support effective communication, information sharing, learning and management of the practice. These included daily meetings for the GPs after morning surgery and monthly study group meetings held in the evening so they did not impact on the availability of appointments for patients. Some of the meetings were for practice staff while others included other health professionals. The topics dealt with during meetings included clinical governance and audit, safety, education, multi-disciplinary information sharing and nursing and dispensary issues. Staff we spoke with confirmed their involvement in meetings and gave us examples of topics discussed including National Institute for Health and Care Excellence guidance, complaints, significant events and in house training.

The practice team were supportive of each other and took part in activities and social events away from work to promote team building and have fun together.

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

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A member of the PPG told us the practice team were now more interested in their views than in the past and that an effective and trusting relationship was developing. The PPG member described their plans which included improving the practice website to include more extensive information and using social media to provide additional avenues for communication.

Are services well-led?

Good

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

The PPG was working to increase the membership and diversity of the group which was actively supporting the practice to develop services for patients. The PPG had a postbox at the main practice and the branch surgery to enable patients to communicate with them. Minutes of PPG meetings and reports were available on the practice website.

The practice was working with the PPG and Age UK to enable them to provide advice and guidance for patients about care pathways and information on a mixture of topics such as dementia, loneliness, grief and heart disease. It was felt this would help patients and carers navigate the range of available services and organisations. About once a month the practice provided Age UK with space to display information and speak with patients. The PPG was planning to start regular 'clinics' at the practice in the Autumn of 2015 staffed by volunteers. The practice would be supporting this with provision of a room, computer access, printing facilities and publicity.

Whilst generally positive the PPG raised concerns about the external environment at the branch practice. They told us that in bad weather this became muddy and collected water which caused problems for the high proportion of older patients who went there. The practice confirmed that they were working with the PPG to resolve this and that a member of the PPG with relevant engineering experience was leading on this. They explained that the situation was complicated because the access was shared with private household stakeholders and there were issues related to drainage, pipes and cables.

Staff told us the partners and practice manager were approachable and that they felt listened to.

Innovation

The practice was in discussions with the other surgery in the building about working in a more collaborative way to manage resources and increase capacity. One of the partners had been involved in founding a federation of 32 GP practices in South Worcestershire and the practice remained involved in the ongoing development of this. The practice manager had been involved in the development of a specialist proactive older people's care team in Worcester.

The practice had employed a physician associate to broaden the skill mix in the clinical team to increase the number of available appointments. They planned to extend this further by employing a nurse practitioner and another physician associate to develop this further. The practice also intended to employ a pharmacist and when we carried out the inspection the practice was in the process of re-advertising for this post. Following the inspection the practice confirmed that two part time pharmacists had been employed to work three days a week as a job share.

Haresfield House was a training practice providing up to two GP training places. A GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP trainees and the practice must have at least one approved GP trainer. The practice was also a teaching practice and provided placements for medical students who had not yet qualified as doctors. They also provided placements for physician associate students.