

York House Medical Centre

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?	Good	
Are services well-led?	Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at York House Medical Centre on 11 November 2015. Overall the practice is rated as good.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses.
- Information about safety was recorded, monitored, appropriately reviewed and addressed. Quality and risk reports were compiled monthly by the practice manager to identify and remedy any issues.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The GPs were leads in different areas and had regular clinical leads meetings to discuss concerns and disseminate learning.

- One of the challenges faced by the practice was the age of the building. The practice had put in a bid for a new building under the primary care infrastructure fund. This was in early stages at the time of the inspection.
- There was a clear leadership structure and staff felt supported by management.
- Risks to patients were assessed and well managed.
- Patients described staff as professional, efficient and helpful.
- The practice had a Carer Support Adviser offering support to patients who were carers. Patients could book an appointment with them via the administration team. Appointments were offered at the surgery and at home.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated good for providing effective services. National patient data showed that the practice was at or above the average for the locality on the whole. For example the performance for diabetes-related indicators was 97.7% which was above the CCG average of 94.4% and above the national average of 89.2%. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Staff had received training appropriate to their roles and the practice believed in developing and training their staff. Staff routinely worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated good for providing caring services. Patients felt involved in their care and treatment and described staff as helpful, professional and kind. Patient information was easy to understand and accessible to patients. We saw staff treated patients with dignity and respect. In the patient survey published in July 2015 it showed that 90.3% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.1% and national average of 85.1%.

Good



Are services responsive to people's needs?

The practice is rated good for providing responsive services. The practice responded to the needs of its local population and engaged well with Wyre Forest Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The practice was well equipped to meet the needs of their patients. Information about how to complain was available and easy to understand. Learning from complaints was shared and discussed at practice meetings. The

Good



Summary of findings

practice worked closely with community well-being buddies. This was a service which signposted patients to the voluntary sector and social services to reduce social isolation and to implement lifestyle changes.

Are services well-led?

The practice is rated good for being well-led. It had a clear vision and strategy. The practice was looking at ways to continuously improve and they had a programme of continuous clinical and internal audit. Staff told us there was an open culture and they were happy to raise issues at practice meetings. The partners were visible in the practice and staff told us they would take the time to listen to them. Staff we spoke with said there was a no blame culture which made it easier for them to raise issues. We saw that there was good morale at the practice.

The practice proactively sought feedback from staff and patients, which it acted on and had an active Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, unplanned admissions and dementia. The practice had a register of patients who had had unplanned hospital admissions and had care plans for each of these patients. The practice had a monthly meeting to discuss unplanned admissions.

The practice was responsive to the needs of older people. For example, the practice offered an enhanced level of care to patients who live in three care homes. Each home had a named GP and patients were visited within 10 days of admission. Each of the residents had a care plan and ward rounds were done every four weeks and more frequently if required. The practice worked closely with the community matron who did weekly ward rounds at the residential homes.

The practice supported the community staff with the virtual ward. These patients had direct access to the community matron. The lead GP met with the community matron on a regular basis and fed back any concerns to the rest of the team at practice meetings.

The lead GP held a Diploma in Palliative Care and worked one day a week at a hospice. Patients' care preferences were communicated at the multi-disciplinary team meetings and out of hours when required.

A pharmacist was present at the practice to offer advice to patients for example after discharge from hospital and after outpatient appointments. The pharmacist was available to respond to medication queries.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Patients with long term conditions had annual reviews.

The practice worked closely with multidisciplinary teams to help patients with long-term conditions.

The clinical leads at the practice met regularly to discuss diabetes, respiratory care, admissions avoidance and anti-coagulation (patients who were on blood thinning medicine).

Good



Summary of findings

The practice offered a shared-care drug monitoring service for the medicines used for patients with rheumatoid arthritis (a disease causing inflammation of the joints). This offered patients a convenient service whilst the need for continuation of the medicines was reviewed via the recall system.

The practice offered a stop smoking service.

Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to follow up on children the practice was concerned about for example children who did not attend appointments. The administration team worked proactively to contact families of children who had not been immunised. There were regular multi-disciplinary meetings at the practice where safeguarding concerns were discussed. The meetings included the lead GP for safeguarding, specialist midwives, health visitor and school nurses.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice worked closely with the fit for work programme; this enabled GPs to refer patients for an occupational health assessment.

The practice offered on-line repeat prescriptions which benefitted those patients with time restrictions.

Appointments were available from 7am to 6pm every day. This included both face to face appointments and telephone appointments. Phlebotomy (blood taking service) was offered at the surgery which avoided the need for patients to go to the local hospital.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice worked closely with community well-being buddies. This was a service which signposted patients to the voluntary sector and social services to reduce social isolation and to implement lifestyle changes.

A community drugs and alcohol worker attended the practice once a week and did a shared clinic with the GPs fortnightly.

The practice had a carer support advisor offering support to patients who were carers. Patients could book an appointment with them via the administration team. Appointments were offered at the surgery and at home.

Good



Summary of findings

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All staff at the practice had received dementia awareness training. There was a community psychiatric nurse attached to the practice. The practice could refer patients to them and they would refer on as required.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing in line with local and national averages for the following area:

- 89% found the receptionists at this surgery helpful which was in line with the CCG average of 91.8% and a national average of 86.9%.

The practice was performing below local and national averages for the following areas:

- 83.5% said they were able to get an appointment to see or speak to someone the last time they tried which was in line with the CCG average of 91.7% and a national average of 85.4%.
- 57% found it easy to get through to this surgery by phone which was below the CCG average of 84.8% and a national average of 74.4%.
- 81.4% said the last appointment they got was convenient which was below the CCG average of 92.9% and a national average of 91.8%.
- 67.2 % described their experience of making an appointment as good which was below the CCG average of 81.4% and a national average of 73.8%.

- 60.4% said they usually waited 15 minutes or less after their appointment time to be seen which was below the CCG average of 69.7% and a national average of 65.2%.
- 51.8% felt they did not normally have to wait too long to be seen which was below the CCG average of 62.9% and a national average of 57.8%.
- 37.8% said they usually got to see or speak with their preferred GP compared with a CCG average of 60.9% and a national average of 60.5%

The practice was aware of these figures and had taken action to improve telephone access.

There were 122 responses and a response rate of 42%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards of which 17 were positive about the standard of care received at the practice. We received five comment cards which had mixed comments. Patients described staff as helpful, informative and efficient. Some of the mixed comment cards contained some negative comments about the building being old and outdated. There were some comments about difficulty contacting the practice by telephone.

York House Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

AC are Quality Commission (CQC) inspector. The team included a GP specialist advisor, a practice manager specialist advisor, a second CQC inspector and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatment from a similar service

Background to York House Medical Centre

York House Medical Centre is based in Stourport on Severn in Worcestershire. The practice is one of five practices belonging to the Wyre Forest Health Partnership.

The practice has five GP partners and six salaried GPs. Seven are female and four are male GPs which provides a choice for patients. The practice has five practice nurses and three healthcare assistants. The clinical team are supported by a practice manager, an assistant practice manager and a team of reception staff and medical secretaries. The practice has a General Medical Services (GMS) contract with NHS England.

The practice is open between 7am and 6.30pm Monday to Thursday and 8am to 6.30pm on Fridays. Appointments are available from 7am to 1pm and 3pm to 6pm in the afternoon.

The practice does not provide out of hours services to their own patients but provides information about the telephone numbers to use for out of hours GP arrangements (NHS 111).

Why we carried out this inspection

We inspected this service as part of our new 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

Before the inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included NHS England and Wyre Forrester Clinical Commissioning Group (CCG). A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. We carried out an announced inspection on 11 November 2015. We sent CQC comment cards to the practice before the inspection and received 22 completed cards giving us information about these patients' views of the practice. During our inspection we spoke with a range of staff and with patients who used the service. We observed how people were being cared for during the inspection.

Detailed findings

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)

Are services safe?

Our findings

Safe track record and learning

The practice prioritised safety and they had a system in place for reporting and recording significant events. During the inspection we saw that within 12 months 83 significant events had been reported. The significant events were categorised into for example diagnosis, administration and medication issues in order to identify trends. Staff used incident forms on the practice's computer system and completed the forms for the attention of the practice manager. In the absence of the practice manager the assistant practice manager dealt with the significant events. The incidents were discussed at the practice meetings. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed and saw evidence of changing practice in response to these. For example, administration staff had discovered a number of un-actioned documents on their computer system. As a result of this administration staff were reminded of the complete process when using the computer system and the practice administrator was given responsibility for periodically checking that no work has been missed. Another example we saw showed a wrong vaccination had been administered. The learning was shared with all the practice to prevent a similar error occurring.

National patient safety alerts were sent to the practice manager who ensured that the GPs and practice pharmacist were aware and any necessary action was taken and documented in individual records.

Overview of safety systems and processes

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

- The practice had systems to manage and review risks to vulnerable children, young people and adults. One of the partners was the safeguarding lead for the practice. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Safeguarding was on the agenda at each of the practice meetings which took place every two months and we saw minutes of these. Staff knew how to

recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were displayed in every clinical room. There was a system to highlight vulnerable patients on the practice's electronic records. Staff described examples of situations where they had identified and escalated concerns about the safety of children. This included working closely with school nurses and health visitors.

- There was a chaperone policy and information to tell patients the service was available on the waiting room noticeboard, consulting rooms and on the practice web site. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. 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.
- There were procedures in place for monitoring and managing risk to patients and staff safety. There was a health and safety policy available and fire training had been given to all staff in September 2015. The practice had fire risk assessments in place and held fire drills regularly. A legionella risk assessment was carried out in September 2015. Legionella is a term for particular bacteria which can contaminate water systems in buildings.
- We observed the premises to be visibly clean and tidy. One of the practice nurses was the infection control lead. There was an infection control protocol in place and staff had received up to date training. An infection control audit was carried out in February 2015 and changes were made as a result of this. For example examination lights had previously not been included in the cleaning schedule but this changed following the audit and wipes were made available to all of the GPs and nurses.
- The practice had a recruitment policy that set out the standards it followed when recruiting clinical and

Are services safe?

non-clinical staff. All staff received a full induction on their first day of employment and had a three month probation review. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment: for example, proof of identity, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

- Staff confirmed they had the equipment they needed to meet patients' needs safely. Each clinical room was appropriately equipped. We saw evidence that the equipment was maintained. This included checks of electrical equipment, equipment used for patient examinations and treatment and items such as weighing scales and refrigerators. The latest electrical check had been carried out in May 2015 and the medical equipment calibration had been completed in April 2015.
- The practice had a policy and procedures for the safe management of medicines and monitoring the use of blank prescriptions which were stored securely. Patients' records were updated when their medicines changed and there was a system for repeat prescriptions which included reviews of patients' medicines. Following a significant event, the practice had strengthened its arrangements for the safe administration and storage of vaccines. The practice

nurses had completed appropriate training and were proactive in maintaining their professional knowledge and experience in respect of vaccine administration. The practice held stocks of controlled drugs (CDs). CDs were stored in a CD cupboard and weekly audits were carried out. The GPs at the practice attended community drug team meetings on a weekly basis.

- There was a sharps injury policy and staff knew what action to take if they accidentally injured themselves with a needle or other sharp medical device. The practice had written confirmation that all staff were protected against Hepatitis B. All instruments used for treatment were single use. The practice had a contract for the collection of clinical waste and had suitable locked storage.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training. There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Oxygen cylinder, defibrillator and emergency medicines were located in the treatment room, all of which were in date. The expiry dates and stock levels of the medicines were being checked and recorded monthly by the nursing team.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurse were able to give a clear rationale for their approaches to treatment. Monthly practice meetings took place and the latest clinical guidelines such as those from National Institute of Health and Care Excellence (NICE) were discussed. Our discussions with the GPs and nurse demonstrated that they completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when considered appropriate. One of the practice nurses explained that nursing staff attended study days arranged by Wyre Forest Clinical Commissioning Group (CCG). A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. For example the practice nurse recently attended a course about the child nasal flu vaccine. Following this the practice nurse cascaded the information to the whole practice at a team meeting. Another change made by a practice nurse following being given responsibility for the flu campaign was to get the GPs at the practice involved in flu clinics so that more patients could receive the vaccination.

The GPs were leads in different areas and had regular clinical leads meetings to discuss concerns and disseminate learning.

The practice had a register of patients for unplanned admissions and had care plans for each of these patients. The practice had a system in place to ensure a GP or nurse called patients within 24 hours of discharge from hospital for patients on the unplanned admissions register and then arranged to see the patient as required. The practice had a monthly meeting to discuss unplanned admissions.

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. Current results were 99.6% of the total number of points available, with 4.9% exception reporting. Exception reporting relates to patients on a

specific clinical register who can be excluded from individual QOF indicators. For example, if a patient is unsuitable for treatment, is newly registered with the practice or is newly diagnosed with a condition.

Data from 2014/15 showed;

- Performance for diabetes-related indicators was 97.7% which was above the CCG average by 4.3% and above the national average by 8.5%
- The percentage of patients with hypertension having regular blood pressure tests was 83.1% which was 1.6% above the CCG average and above the national average by 2.7%.
- Performance for mental health related and hypertension indicators was 86.1% which was above the CCG average by 1.4% and above the national average by 4.6%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patients' outcomes. There had been one clinical audit completed in the last two years; the second audit had not yet been re-audited.

The first audit was an audit on urinary tract infections (UTIs) in males. The second audit was on prescribing of a medication used for anxiety allowing reductions wherever possible.

Effective staffing

We found that the GPs valued the importance of education and effective skill mix. York House Medical Centre is a training practice providing GP training places for two GP trainees. 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 also provided placements for fifth year medical students from Birmingham University who had not yet qualified as doctors.

The learning needs of staff were identified through a system of appraisals and meetings. The practice told us that staff had the essential training for their role and also did electronic training modules such as safeguarding, equality and diversity and fire training. Further training needs were identified at appraisals on an individual basis. The GPs had protected learning time every month.

Are services effective?

(for example, treatment is effective)

Staff at the practice had the skills, knowledge and experience to deliver effective care and treatment. At appraisals the practice nurses had asked for further training in childhood immunisations and meningitis B. The nurses have completed this training and they felt that the GPs had been supportive of their training needs.

Coordinating patient care and information sharing

The practice used electronic systems to communicate with other providers and to make referrals. Staff felt that the system was easy to use and patients welcomed the ability to choose their own appointment dates and times through the Choose and Book system. Choose and Book enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. Scanned paper letters were saved on the system for future reference. All investigations, blood tests and X-rays were requested and the results were received electronically.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. The practice had a system in place to ensure a GP or nurse called patients within 24 hours of discharge from hospital for patients on the unplanned admissions register and then arranged to see the patient as required. We saw evidence that

multi-disciplinary team meetings took place on a quarterly basis and that care plans were routinely reviewed and updated. The meetings involved Macmillan nurses, district nurses and health visitors.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Health promotion information was available in the waiting area of the practice. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 84.2%, which was above the national average by 2.4%.

- Flu vaccination rates for the over 65s were 75.51% this was above the national average of 73.24%.
- Flu vaccination rates for those patients in the at risk groups were 60.35%, above the CCG average of 52.29%. The percentage of patients diagnosed with dementia whose care had been reviewed in the last 12 months was 82% compared with the national average of 84%.

The practice also carried out NHS health checks for people aged 40-74 years.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Results from the national GP patient survey published in July 2015 showed that patients were happy with how they were treated. The practice was in line with and in some cases above average for its satisfaction scores on consultations with doctors and nurses for example:

- 89.9% said the GP was good at listening to them compared to the CCG average of 91% and the national average of 88.6%.
- 87.1% said the GP gave them enough time compared to the CCG average of 89.6% and national average of 86.8%.
- 92% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.3% and the national average of 95.3%.
- 90.3% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.1% and national average of 85.1%.
- 90.2% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92.3% and the national average of 90.4%.
- 89% patients said they found the receptionists at the practice helpful compared to the CCG average of 91.8% and the national average of 86.9%.

We reviewed 22 CQC comment cards completed by patients prior to the inspection. Patients commented positively on the helpful and supportive way that staff treated them. We spoke with 15 patients on the day of our inspection; this included four members of the patient participation group (PPG). A patient participation group is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Almost all of the patients were satisfied with the care they received from the practice and commented that staff were professional, informative and helpful. Their approach was kind and caring at all times.

Patients' privacy and dignity was maintained. For example, a private room was made available for when patients

wanted to talk in confidence with the reception staff to reduce the risk of conversations being overheard. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained.

We spoke with the managers of the three care homes where the practice looked after patients and they all spoke very highly of the GPs describing them as caring, supportive and efficient. They explained that the GPs would visit once a month but would come straight away if a patient needed to be seen and were always supportive.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above the local and national averages for GPs explaining tests and treatments:

- 89.1% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86.3%.

Results were in line with local and national averages for the following area:

- 78.7% said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 83.9% and the national average of 81.5%.

Staff we spoke with told us that translation and interpreting services were available for patients who did not have English as a first language. This was advertised in waiting areas. Staff also had access to British Sign Language interpreters for patients as required. The practice had visual cards for patients with learning disabilities to support their care needs.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice and rated it well in this area. Notices in the patient waiting room sign posted people to a number of support groups and organisations.

Are services caring?

The practice had a register of carers. Carers known to the practice were coded on the computer system so that they could be identified and offered support. All carers were seen annually. Of the practice list 3.7% of patients were identified as carers.

The practice had a Carer Support Adviser offering support to patients who were carers. Patients could book an appointment with them via the administration team. Appointments were offered at the surgery and at home.

Support was provided to patients during times of bereavement. Staff we spoke with recognised the importance of being sensitive to patients' wishes.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with Wyre Forest Clinical Commissioning Group (CCG) to plan services and improve outcomes for patients in the area. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The CCG informed us that the practice engaged well with them.

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

- The practice offered an enhanced level of care to patients who lived in three residential and nursing homes. Each home had a named GP and patients were visited within 10 days of admission. Each of the patients had a care plan and ward rounds were done every four weeks and more frequently if required. The practice worked closely with the community matron who did weekly ward rounds at the residential homes.
- The practice had a virtual ward for vulnerable patients. These patients had direct access to the community matron. The lead GP met with the community matron on a regular basis and fed back any concerns to the rest of the team at practice meetings.
- The lead GP held the Diploma in Palliative Care and worked one day a week at a hospice. The practice had a register of patients who were receiving palliative care and a monthly multi-disciplinary palliative care team meeting was held at the practice. At this meeting the practice reviewed patients who were on the palliative care register. The practice had systems in place to support patients who were reaching the end of their life. Patients' care preferences were communicated at the multi-disciplinary team meetings and out of hours when required.
- The practice had a medicines optimisation programme whereby a pharmacist was present at the practice to offer advice to patients for example after discharge from hospital and after outpatient appointments. The pharmacist was there to offer easy access to medication queries. This reduced the risk of medication errors.
- The practice worked closely with multidisciplinary teams to help patients with long-term conditions. The clinical leads at the practice met regularly to discuss diabetes, respiratory care, admissions avoidance and anti-coagulation (patients who were on blood thinning tablets).
- The practice offered a shared-care drug monitoring service for the medicines used for patients with rheumatoid arthritis (a disease causing inflammation of the joints). This offered patients a convenient service whilst the need for continuation of the medicines was reviewed via the recall system.
- The practice offered a specialist service called QUIT 51 (a stop smoking service).
- Appointments were available from 7am to 6pm every day. This included both face to face appointments and telephone appointments.
- Phlebotomy (blood taking service) was offered at the surgery which avoided the need for patients to go to the local hospital.
- The practice worked closely with the fit for work programme. This enabled GPs to refer patients who have been off sick for an occupational health assessment.
- The practice offered on-line repeat prescription which benefitted those patients with time restrictions.
- The GPs at the practice had specialist interest in ophthalmology (eye care), dermatology (skin care), gynaecology (women's health) and palliative care (end of life care). This meant that patients could get advice from the GPs without unnecessary secondary care appointments. It enabled care to be delivered closer to home for patients.
- The practice worked closely with community well-being buddies. This was a service which signposted patients to the voluntary sector and social services to reduce social isolation and to implement lifestyle changes.
- The practice had links with health trainers who offered free and confidential advice to anyone in Worcestershire aged over 16. They were local trainers who were able to provide one-to-one support to help achieve a healthier lifestyle.
- A community drugs and alcohol worker attended the practice once a week and did a shared clinic with the GPs fortnightly.
- There was a community psychiatric nurse attached to the practice. The practice could refer patients to them and they would refer on as required.

Are services responsive to people's needs?

(for example, to feedback?)

- The practice had a large number of patients who were travellers. The practice nurse attended training to understand any individual needs and to encourage up take of child immunisations.

The practice also provided the following:

- There were longer appointments for people with a learning disability.
- Home visits were available on request for older patients and patients who would benefit from these.
- ;p;Parking facilities for disabled patients.
- Ramps were available for wheelchair users and for people with pushchairs.
- The practice had a hearing loop and translation services.

Access to the service

The practice was open between 7am and 6.30pm Monday to Thursday and 8am to 6.30pm on Fridays. Appointments were available from 7am to 1pm and 3pm to 6pm. Urgent appointments were available on the same day and patients could book their appointments up to 4 weeks in advance.

The practice has a hearing loop and disabled toilets. There are designated disabled parking spaces on the road outside the building. Some downstairs consulting rooms have extra wide doors. There is a ramp into the building. The practice provides patient services over two floors but normally aims to see disabled patients on the ground floor whenever possible.

Results from the national GP patient survey published in July 2015 showed that patients' satisfaction with how they could access care and treatment was lower than local and national averages. Most patients we spoke with on the day of the inspection said they were able to make appointments when they needed to.

- 71.8% of patients were satisfied with the practice's opening hours compared to the CCG average of 81.1% and national average of 75.7%.
- 57% of patients said they could get through easily to the surgery by phone compared to the CCG average of 84.8% and national average of 74.4%.
- 67.2% of patients described their experience of making an appointment as good compared to the CCG average of 81.4% and the national average of 73.8%.
- 60.4% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69.7% and national average of 65.2%.

The practice was trying to address the lower than average national survey results by making improvements to their telephone system to improve access.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints at the practice.

We saw that information was available to help patients understand the complaints system on the website and leaflets were available which set out how to complain and what would happen to the complaint and the options available to the patient.

We looked at the formal complaints received in the last year and found these had been dealt with according to their policy and procedure. We saw evidence that complaints were discussed at practice meetings and lessons were learned from these. For example, one of the complaints we reviewed was about a misdiagnosis. As a result of this the GPs discussed this at the practice meeting and there was a change of practice to request an additional blood test to prevent this occurring again.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice is one of five practices belonging to the Wyre Forest Health Partnership. The Chief Executive of the Wyre Forest Health Partnership worked closely with the GP partners and practice manager and had a dual level responsibility. The practice had values which were embedded at all levels across the practice. The values were to be caring, committed and to work with integrity. Ideas were shared between all of the practices of the Wyre Forest Health Partnership.

One of the challenges faced by the practice was that the premises was no longer fit for purpose. The practice had put in a bid for a new building under the primary care infrastructure fund. This was in early stages at the time of the inspection.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity.

- There was a clear leadership structure with the Chief Executive of the Wyre Forest partnership working closely with the practice manager and GPs. There were named GPs in lead roles.
- There were robust arrangements for identifying, recording and managing risk. Quality and risk reports were compiled monthly by the practice manager to identify and remedy any issues.
- The practice had a programme of continuous clinical and internal audit which was used to monitor quality and make improvements.
- The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards. QOF was regularly discussed at practice meetings.

Leadership, openness and transparency

Meetings were held regularly and minutes kept and circulated to the team. The GP leads had meetings every week and practice meetings were held monthly.

Staff told us there was an open culture and they were happy to raise issues at practice meetings. The partners were visible in the practice and staff told us they would take the time to listen to them. Staff we spoke with said there was a no blame culture which made it easier for them to raise issues. We saw that there was good morale at the practice.

We saw evidence that staff had annual appraisals and were encouraged to develop. For example the practice manager had started off as an apprentice and worked their way up through the practice by being given the opportunity to undertake the relevant training courses.

All staff were encouraged to identify opportunities to improve the service delivered by the practice. Staff interacted with each other socially.

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

The importance of patient feedback was recognised and there was an active patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We met with four members of the PPG during the inspection. The PPG had ten members and met every two months.

The practice was working closely with the PPG and had made a few recommendations which the practice had implemented. For example a few members of the PPG had carried out some observations in different areas of the practice. Previously the practice had a system whereby when patients called the practice the phone would ring out until answered. Following the patient survey results this has been changed to a queueing system which patients told us was much better. The PPG had also implemented shorter surveys to obtain feedback from patient. For example they shared the results of their last telephone survey which showed that 90% of patients were happy with electronic prescribing.

Staff we spoke with said they would not hesitate to give feedback and all felt valued by the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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