Hillview 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection November 2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Hillview Medical Centre on 17 January 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. The practice discussed incidents as soon as they happened, learned from them and improved their processes where necessary.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered in accordance with evidence- based guidelines.
- The practice worked collaboratively with other local practices and organisations to develop schemes which would benefit patients in the area. For example, the neighbourhood team, extended hours hubs and social prescribing (a way of linking patients in primary care with sources of support within the community).
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients told us that the appointment system was easy to use and said that they were able to access care when they needed it. Routine appointments were available within 48 hours.
- The practice had a computer software programme that automatically recorded future diary entries for patients who needed to be recalled for reviews.

Summary of findings

- The practice had developed a protocol for prescribing end of life medicines which was going to be cascaded to other practices in Worcestershire.
- There was a focus on continuous learning and improvement at all levels of the organisation.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General 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
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Hillview Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and supported by a GP specialist advisor.

Background to Hillview Medical Centre

Hillview Medical Centre is registered with the Care Quality Commission (CQC) as a partnership provider. It is located in a residential area of Redditch in Worcestershire. The practice holds a General Medical Services (GMS) contract with NHS England. The GMS contract is a contract between general practices and NHS England for delivering primary care services to local communities. At the time of our inspection Hillview Medical Centre was providing medical care to 9,102 patients. The practice has a website, which details services and gives information to patients: www.hillviewmedcentre.co.uk.

The practice provides additional GP services commissioned by Redditch and Bromsgrove clinical commissioning group (CCG). For example, minor surgery. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

All consulting rooms are located on the ground floor. Bus stops are situated just outside the practice and Redditch rail station is a few minutes' walk away. Parking is available on site and in a nearby car park accessed by a slip road to the side of the practice. There is provision for parking for disabled patients at the rear of the practice building and the practice has facilities for disabled patients. There is an independent pharmacy on site.

The practice team consists of five GP partners (two male and three female) and two salaried GPs (one male and one female). They are supported by the practice manager, a pharmacist, three practice nurses, a health care assistant, and reception and administrative staff.

Hillview Medical Centre is open on weekdays from 8.30am until 6pm. Appointments are available from 8.40am until 11.30am and from 2.30pm until 6pm. Extended hours appointments are provided from 7.10am on Tuesdays and Thursdays, from 7.20am on alternate Mondays and Fridays and from 7.30am on Wednesdays. Patients who ring the practice between 8am and 8.30am and between 6pm and 6.30pm hear a recorded message which advises them to ring a mobile number if they need to see a GP urgently during the week (practice staff answer the mobile). The practice is closed at weekends.

An out of hours service is provided by Care UK for Redditch and Bromsgrove CCG. Patients can access this by using the NHS 111 service.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse.

The practice had systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were reviewed annually and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Staff had received training in safeguarding to a level appropriate for their role and knew how to identify and report any concerns. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to contact for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- Inbuilt safety netting protocols ensured that concerns about children could be recorded when they were not serious enough to be included on the safeguarding register.
- Automated computer searches ran every month so that practice staff could check if a patient had not attended for regular injections, tests or scans.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). We saw that risk assessments were carried out when new members of non-clinical staff were recruited in order to document the decision not to undertake a DBS check.
- Staff who acted as chaperones were trained for the role and had received a DBS check. Non-clinical staff were not required to act as chaperones.
- There was an effective system to manage infection prevention and control (IPC). The practice nurse was the IPC lead and carried out regular audits. The last audit was carried out in May 2017. We saw that action was taken to address any issues found in the audits. For example, hand gel was now provided in reception for use by staff who had to handle specimens.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was a verbal induction system for locum doctors.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. A sepsis poster was displayed in the reception area.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines, but they were not always effective.

- The systems for managing vaccines, medical gases, and equipment minimised risks. The stock of medicines for use in an emergency was stored in four different places. The practice subsequently informed us that all the emergency medicines were now kept in one location, with the exception of one, which was kept with the

nebulizer (a device used to administer medicine in the form of a mist which is inhaled into the lungs). One of the emergency medicines normally held was missing when we inspected, despite regular checks. It was replaced when the omission was highlighted. The GP partners provided evidence that they had risk assessed the range of emergency medicines stocked. We were told that there was an independent pharmacy on site, which was open at all times that the practice was open, so this factor influenced the range of emergency medicines stocked by the practice.

- Prescription stationery was kept securely and tracked in the practice.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing and we saw that prescribing of a certain antibiotic in line with Worcestershire Antimicrobial Guidelines had improved as a result. There was evidence of actions taken to support good antimicrobial stewardship. Staff knew where to access current guidelines. The practice participated in the Improving Quality and Supporting Practices (IQSP) scheme, which involved a supportive process of audit and peer review through a programme of clinically led practice visits. As part of this scheme, practice prescribing trends were monitored and compared with other practices in the locality.
- Patients' health was monitored to ensure that medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses.
- There were systems for reviewing and investigating incidents. The practice learned and shared lessons and took action to improve safety in the practice. Three incidents were logged in 2017. We saw that the practice had changed their procedures for checking patients' identity when attending for consultation in response to an incident, and all staff were made aware of this. Incidents were discussed informally in the daily clinical meetings and discussed more formally in quarterly meetings attended by senior members of staff. Any learning points were then cascaded to relevant staff.
- The practice learned from external safety events as well as patient and medicine safety alerts. The practice had a system for receiving and actioning both patient safety alerts and drug safety updates. The prescribing lead and practice manager had oversight of the alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice had offered 179 patients a health check and 175 of these checks had been carried out.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice held regular meetings with multi-disciplinary staff in line with the gold standard framework.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, diabetes and asthma.
- A software programme automatically inserted future diary dates for recalls for patients with long term conditions, which reduced the likelihood of recalls being overlooked.
- The practice was working with other local practices to develop a Neighbourhood Team scheme which would provide case management for patients with complex needs.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- Priority was given to children under the age of 10.
- Two GPs had a special interest in paediatrics, which benefitted patients and colleagues.

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

- The practice's uptake for cervical screening was 77%, which was in line with the 81% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had developed a protocol for prescribing end of life medicines which was going to be cascaded to other practices in Worcestershire.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

People experiencing poor mental health (including people with dementia):

Good

Are services effective?

(for example, treatment is effective)

- The practice had responsibility for three care homes in the local area. A nominated GP was allocated to each of the homes and weekly ward rounds were carried out.
- 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is in line with the national average.
- 94% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is in line with the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 85%; CCG 92%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 95%; CCG 96%; national 95%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity, which included audits, and routinely reviewed the effectiveness and appropriateness of the care provided. Clinicians took part in local and national improvement initiatives. For example, the practice was working with practices in the area to develop a neighbourhood team scheme, which would provide integrated care for patients with complex needs.

The most recent published Quality Outcome Framework (QOF) results showed that the practice achieved 99.4% of the total number of points available compared with the clinical commissioning group (CCG) average of 98.4% and national average of 95.5%. The overall exception reporting rate was 7% compared with the CCG average of 8% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, staff had attended external training sessions on scanning and healthcare navigation.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

Good

Are services effective?

(for example, treatment is effective)

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. Patients were also encouraged to attend national programmes for breast and bowel screening.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

We saw that staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 25 patient Care Quality Commission comment cards we received were positive about the service experienced. There was one negative comment included about the number of car parking spaces. Patients wrote that doctors and nurses listened to them and that they did not feel rushed during consultations. Receptionists were said to be kind, polite and helpful. This aligned with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual National GP Patient Survey showed that patients felt that they were treated with compassion, dignity and respect. 259 surveys were sent out and 128 were returned. This represented a 49% completion rate and about 1% of the practice population. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 89% of patients who responded said the GP gave them enough time; CCG - 88%; national average - 86%.
- 96% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 81% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 87%; national average - 86%.
- 92% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 94% of patients who responded said the nurse gave them enough time; CCG - 95%; national average - 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 99%; national average - 97%.
- 91% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.
- 89% of patients who responded said they found the receptionists at the practice helpful; CCG - 87%; national average - 87%.

We were told that the survey results were the highest in Redditch for the second year in a row.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were provided for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, Easy read versions of the practice leaflet and complaints leaflet could be printed off if required.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice identified patients who were carers. There was a question included on the new patient questionnaire and there was a Carers' Direct page on the practice website, which advised people to let the practice know if they were carers and listed details of support services. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 101 patients as carers, which represented 1% of the practice list.

Staff told us that if families had experienced bereavement, their usual GP would contact them and offer advice on support services available.

Good

Are services caring?

Results from the National GP Patient Survey showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 82% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 88% and the national average of 86%.
- 79% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 82%; national average - 82%.
- 91% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 86% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- There were signs by the reception desk requesting that patients respect the confidentiality of other patients.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, patients could register for online services such as repeat prescription requests, text reminders and advance booking of routine GP appointments. Advice for minor illnesses and long term conditions was available on the practice's website.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, a portable hearing loop was available in reception.
- The practice promoted the 'Message in a Bottle' scheme run by a local voluntary organisation. The idea was to encourage people to keep their personal and medical details on a standard form in a bottle and in a common location (the refrigerator), where the emergency services would be able to find it in the event of an emergency.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice had signed up to the Care Home Enhanced Service. A nominated GP carried out weekly ward rounds at each of the three care homes for which the practice had responsibility. We spoke with two managers who said that they were happy with the level of care provided.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.
- The Carer Support Worker from the Worcester Association of Carers attended the end of life meetings.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- Weekly diabetic clinics were held at the practice by practice clinical staff.
- The practice held regular meetings with multi-disciplinary staff to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 10 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were provided early in the morning on every weekday. This service was convenient for people who could not attend during core opening hours.
- Telephone consultations were available which provided flexibility for patients who were unable to attend the practice during core opening hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients with a learning disability. There were no homeless people or travellers registered at the time of our inspection, but the practice was able to tell us how they would be registered if required.
- Information about domestic abuse services was displayed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Two staff had received dementia friendly training.
- A Gateway health worker held clinics once a week at the practice.
- Patients over the age of 16 could self-refer or be referred by their GP to the Worcestershire Healthy Minds Wellbeing Hub and counselling service.
- A GP was the lead for mental health for the Redditch and Bromsgrove clinical commissioning group.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients told us that the appointment system was straightforward to use.

Results from the National GP Patient Survey showed that patients' satisfaction with how they could access care and treatment were above local and national averages. This was supported by what we saw on the day of the inspection and aligned with the completed comment cards. Patients wrote that it was easy to make an appointment. 259 surveys were sent out and 128 were returned. This represented about 1% of the practice population.

- 85% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 92% of patients who responded said they could get through easily to the practice by phone; CCG – 77%; national average - 71%.
- 91% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 88%; national average - 84%.
- 91% of patients who responded said their last appointment was convenient; CCG - 84%; national average - 81%.
- 83% of patients who responded described their experience of making an appointment as good; CCG - 75%; national average - 73%.
- 66% of patients who responded said they don't normally have to wait too long to be seen; CCG - 55%; national average - 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was straightforward to do. The practice manager was the lead for complaints. Staff treated patients who made complaints compassionately.

The complaint policy and procedures were in line with recognised guidance. Five complaints were logged in the last year. We reviewed the complaints and found that they were satisfactorily handled in a timely way in accordance with the complaints policy.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the practice was considering expanding the remit for the pharmacist and employing a physician's associate in order to provide additional capacity to meet the demand from the increasing patient list size.
- The GP partners and management team were visible and approachable.
- The practice had processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a strategy for the future, which was due to be discussed at a partnership meeting scheduled for a couple of weeks after our inspection.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- It was clear that practice staff focused on the needs of patients.
- The GPs and management team acted on behaviour and performance inconsistent with the vision and values. A GP had overall responsibility for human resource management, although day to day responsibility was devolved to the practice manager.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us that they were able to raise concerns or suggestions for improvement with their line manager or the practice manager.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. We noted that the regular appraisal system lapsed in 2017. At the time of our inspection, staff confirmed that pre-appraisal forms had been circulated and that they were waiting for dates for their appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered to be valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was an emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between the GP partners and management team and staff.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

Are services well-led?

Good

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control (IPC). There were designated practice leads for safeguarding and IPC.
- Policies, procedures and activities had been established to ensure safety and these were reviewed on a regular basis.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of patient safety alerts, drug safety updates, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. The disaster recovery plan was available both in hard copy and on the practice intranet. Two GP partners and the practice manager had access to it off site.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The practice used performance information to keep track of progress against local and national targets.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. For example, a software programme automatically populated future diary recall dates for patients and non-attenders were followed up.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- There was a virtual patient participation group. The practice manager emailed members of the group with updates and news of local healthcare related events.
- A GP was chair of the Redditch and Bromsgrove GP Advisory Forum and chair of the Alliance. The practice was working with five local practices to develop a Neighbourhood Team, which would provide integrated care for patients with complex needs. Meetings started in January 2018. The practice was also working to provide four extended access hubs in the Redditch and Bromsgrove area.
- Patients could sign up to receive the practice newsletter by email. The newsletter was produced twice a year and was also available on the practice website and in reception.
- The practice manager wrote the successful bid for funding for a social prescribing 12 month pilot service, which would benefit patients from nine local practices. The social prescribing pilot would enable patients to be referred in to the service and signposted to appropriate non-medical and community support services. For example, Age UK.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice.
- Staff knew about improvement methods and had the skills to use them.

Are services well-led?

Good

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

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- The practice was affiliated to the Primary Care Research Network at Warwick University and patients were invited to take part in studies such as gout.