The Ridgeway Surgery

Quality Report

6-8 Feckenham Road,
Astwood Bank,
Redditch,
Worcestershire
B96 6DS
Tel: 01527 892418
Website: www.theridgewaysurgery.co.uk

Date of inspection visit: 24 November 2014
Date of publication: 19/02/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 24 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the effective, caring, responsive and well-led domains and required improvement in the safe domain. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.
- Systems and processes to address risks to patients were not implemented well enough to ensure patients were kept safe at all times. The practice had a system in place for reporting, recording and monitoring significant events over time. However, the scope of reporting needed to be widened to include other incidents.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Review the system for recording safeguarding information for vulnerable adults and children to ensure that information is recorded consistently in patients' records.
- Ensure that the recruitment policy covers clinical staff and makes reference to all of the information required.

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?

Requires improvement

The practice is rated as requires improvement for safe as there are areas where improvements should be made. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to staff to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. National safety alerts for medicines had not been followed thoroughly enough.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence(NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff at the practice had personal development plans and received appraisals. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others nationally for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was an active patient participation group (PPG) in place that met four times a year. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and urgent access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who failed to attend appointments or clinics. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. They had carried out annual health checks for people with a learning disability. They had offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice offered reviews of all patients with severe and enduring mental health conditions with at least annual reviews of their physical, social and mental health, medicines and revision of their agreed care plan. In-house counselling was also available at the practice. Patients with dementia were also offered an annual review.

Patients newly diagnosed with dementia were referred to Kidderminster Early Dementia Service, which was provided by the local community trust. The Admiral Nurse (specialist dementia nurse) service was available to support families in caring for relatives affected by dementia. It also provided an educational and consultancy role to professionals. Patients could self refer to the Admiral Nurse based in Redditch or this could be done by the GP. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient told us that reception staff were sometimes abrupt. Three patients told us the appointments always ran late. However, patients told us this was because the GPs spent time with patients and listened to them.

We received 11 completed comment cards and with the exception of three, they were all positive about the service experienced. For the three less positive comment cards the theme was that appointments always ran late. One patient told us that you had to wait for up to two weeks to see a GP of choice. Most patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. All patients said the staff treated them with dignity and respect.

We spoke with a representative of the patient participation group (PPG). (PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive). They told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes to them and listened to any concerns they had. They told us patients did not have to wait to see a GP. However, they may have to wait to see their named GP.

We spoke with a manager from the care home that was supported by the practice. They described to us the caring, professional and supportive attitude of the GPs. They told us it was a good practice that listened to them and worked well with them to make sure the people they cared for received the best care.

We reviewed the most recent data available for the practice on patient satisfaction. This was the information from the national GP patient survey published in July 2014. The evidence from this source showed that the majority of patients were satisfied with the service offered by the practice. For example, data from the national patient survey showed that 79% of patients would recommend the practice. The practice was well above average for its satisfaction scores on consultations with GPs; 94% of practice respondents confirmed that the GP was good at listening to them, 93% responded that the GP gave them enough time and 96% had confidence and trust in the last GP they saw or spoke to. These results were all above the national average.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

• Review the system for recording safeguarding information for vulnerable adults and children to ensure that information is recorded consistently in patients' records.

• Ensure that the recruitment policy covers clinical staff and makes reference to all of the information required.

The Ridgeway Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice nurse specialist advisor and an expert by experience who has personal experience of using primary medical services.

Background to The Ridgeway Surgery

The Ridgeway Surgery is located in Astwood Bank and provides primary medical services to patients at the Astwood Bank surgery and the branch surgery in Feckenham. The practice is located at the north of the area that it covers which includes Upper Bentley, Broughton Hackett, The Lenches and Coughton.

The practice has four GP Partners (two male and two female), a practice manager and a dispensary manager. There are two practice nurses, three healthcare assistants, one phlebotomist (a specialised healthcare assistant who collects blood from patients), two dispensers and reception and administrative staff. There are 5,213 patients registered with the practice. The practice is open for medical availability 8am to 6.30pm Monday to Friday. Patients can access an on line booking service which is also available. There is a walk in surgery at Feckenham branch surgery on a Monday, Wednesday and Friday between 2.15pm and 3.30pm. The doors to the surgery are open from 2pm. The practice treats patients of all ages and provides a range of medical services. The Ridgeway Surgery has a higher percentage of its practice population in the 45 to 85 and over age group than the England average.

The Ridgeway Surgery provides 19 GP sessions, 10 nurse and eight healthcare assistant sessions each week. At the branch surgery there are three GP sessions provided each week.

The Ridgeway Surgery is a dispensing practice. They are able to dispense medicines to patients in a rural area who do not have a chemist within one mile (1.6km) radius of their home address. Medicines are also dispensed from their branch surgery.

The Ridgeway Surgery has a General Medical Services contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice was inspected by CQC in July 2013 as part of a routine inspection programme and they were compliant with all of the areas inspected. This inspection report is available on our website www.cqc.org.uk.

The practice provides a range of services including specific ones for patients with respiratory problems, diabetes and heart disease. It offers child immunisations, influenza and travel vaccinations (excluding yellow fever) and maternity and family planning services. The practice also provides a minor surgery and phlebotomy (taking blood) service.

The Ridgeway Surgery does not provide an out-of-hours service to its own patients. Outside the hours they are open they advise patients to contact the NHS 111 service. This information was available at the practice and on the practice website.

Why we carried out this inspection

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

Detailed findings

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

Please note that 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. We received information from the Clinical Commissioning Group (CCG) and the NHS England Area Team (AT).

We carried out an announced inspection on 24 November 2014. During our inspection we spoke with three GPs, one practice nurse, the practice manager, the dispensary manager, one phlebotomist who was also a receptionist and one administrative member of staff who also worked in the dispensary. We spoke with seven patients who used the service about their experiences of the care they received. We reviewed 11 patient comment cards from patients sharing their views and experiences of the practice. We also spoke with a representative from the patient participation group and the provider and care manager from a care home who received a service from the practice. We also looked at procedures and systems used by the practice.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

We saw that the practice had systems in place to assess and monitor the consistency of their performance over time. We saw records which showed that multiple sources of information were used by the practice to check the safety of the service and action was taken to address any areas in need of improvement. These included significant events and complaints. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns.

Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place. For example, we saw that the annual complaints report dated 2014 showed a recent clinical complaint had been raised as a significant event by the practice nurse. This was scheduled for discussion at the practice meeting on 10 December 2014.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records for significant events for 2013 to 2014 were made available to us. Staff told us they were responsible for completing significant event forms, and significant event analysis was carried out each time there was a patient safety incident. Staff told us they were informed of the outcome from these and debriefed through staff meetings. Following significant events the practice developed action plans to ensure improvements so that the incident did not happen again.

We saw that incident forms and templates were available on the practice computer system and staff had access to them. The practice manager and a GP told us incidents were discussed at practice management and staff meetings. Minutes of the GP partners meetings held bi-monthly showed that significant events were a standard agenda item for discussion. We looked at the practices summary of significant events for 2013 to 2014. We saw that there were five recorded in total and the most recent dated 27 October 2014 was scheduled for discussion at the practice management meeting on 10 December 2014. We saw that very little detail was recorded for each event. An outcome was completed for all and an action point was recorded for one event. There was no information to demonstrate that these events had been signed off as complete and if there were any identified learning points from these incidents. However, following the outcome of another significant event in November 2013 we saw that the practice had recognised an increased demand for appointments in the month of December. The practice manager told us an extra GP session was planned for Mondays throughout December 2014.

National patient safety alerts, medical devices alerts and other patient safety alerts were disseminated by email to practice staff. Staff told us they received these by email from the practice manager. A GP told us paper copies of the alerts were also held in a designated folder. We saw that this folder was available to staff at the practice. We found national safety alerts for medicines had not been followed thoroughly enough by the GPs. For example, we saw that eight patients were on Simvastatin (used to lower cholesterol levels) 40mgs and Amlodipine (used to widen blood vessels and improve blood flow) 10mg. This combination of medicines was subject to a safety alert in October 2012. We also found that there were two other medicines that needed to be reviewed with patients from safety alerts dated August 2013 and May 2014. There was no recorded evidence to show that the risks of taking these medicines or the use of a suitable alternative (if applicable) had been discussed with these patients. Minutes of practice meetings did not provide any information to show safety alerts were reviewed at these meetings. One day after the inspection a GP sent us information to show what action they had taken following the inspection feedback. They had done a search of their patients to identify all patients on the medicines subject to safety alerts. Patients had been contacted by telephone and their medicines in some cases had been stopped and an alternative prescribed. Some patients had been sent letters which advised them about the medicines and the need to urgently review them with their GP. Appropriate action had been taken by the practice for all medicines subject to the identified safety alerts.

To prevent any reoccurrence of these findings, the GP told us they had signed up for the alerts to come directly to them as well as the practice. The GP told us searches for medicines subject to previous safety alerts would be done

by the practice on a quarterly basis or more often if the need arose. Any patient safety alerts would be added to the information discussed at the weekly meetings they already had in place with the practice manager.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We saw that contact details were easily accessible as they were displayed on the wall in the staff area upstairs.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to level three (advanced), and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures through the practice's intranet site or printed copies were available. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. For example, a staff member told us how an older person was distressed when speaking with them on the telephone and how this had been followed up. The safeguarding lead told us the last safeguarding referral was made in September 2014.

Patients individual records were written and managed in a way that helped to ensure their safety. Records were kept on an electronic system called EMIS, which collated all communications about the patient including scanned copies of communications from hospitals. Staff told us that the system was used to highlight vulnerable patients which ensured staff were alerted to any relevant issues when patients attended appointments. We found that GPs used the required codes on this electronic case management system to ensure risks were clearly flagged and reviewed. However, we saw two records where these alerts were not in place. Two days after the inspection the practice sent us information that told us the GP lead for safeguarding had ensured that screen alerts were in place for all patients where there were safeguarding concerns.

A chaperone policy was in place and information about the service was available adjacent to the appointment check in screen and in consulting rooms. Staff told us that they always asked patients whether they required a chaperone when they received any intimate treatment. Discussion with patients confirmed this. Staff told us that chaperone duties were carried out by clinical and reception staff. Training records showed reception staff had received chaperone training. Discussion with reception staff confirmed this.

Medicines management

We checked medicines stored by the practice in the treatment room, dispensary and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring refrigerated medicines were kept within the temperature guidelines recommended by the manufacturer. This was followed by the practice staff, and the action to take in the event of a potential failure was described. However, there were no procedures in place to ensure that non-refrigerated medicines stored at the practice were kept within the temperature guidelines recommended by the manufacturer.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Medicines were administered safely. We saw there were signed Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a GP, enabling a nurse to administer a medicine to groups of patients without individual prescriptions.

The practice had a protocol for repeat prescribing which was in line with General Medical Council (GMC) guidance that was last reviewed in March 2014. This covered how staff that generated prescriptions were trained, how changes to patients' repeat medicines were managed and the system for reviewing patients' repeat medicines.

Requires improvement

Are services safe?

The practice was able to provide pharmaceutical (medicines) services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises. This service was also available at their branch surgery. A dispensary manager was employed to oversee the quality of the dispensing of the medicines. Controlled medicines were stored securely in the dispensary. The standard operating procedure for controlled medicines showed that they were handled in line with legal requirements. The dispensary used a computerised system for stock control and ordering of medicines. There were standard operating procedures in place relating to dispensing of prescriptions. Dispensing staff told us that prescriptions were not dispensed unless they had been signed by a GP. The dispensary manager confirmed this. Dispensing staff described and showed us the systems in place for the safe storage and monitoring of prescription pads to prevent them from being stolen and used inappropriately.

Cleanliness and infection control

There were systems in place to keep patients safe from the risk and spread of infection. There was an appropriate infection control policy available for staff to refer to. We saw that the infection control lead had received appropriate infection control training. Records showed that all staff had received infection control training. This was confirmed by staff we spoke with.

An infection control audit had been carried out in November 2014. An action plan was in place for any shortfalls that were highlighted. For example, the availability of sterile single use nail brushes for minor surgery. We saw that these had been ordered. We saw that single use instruments were used and they were in date. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

On the day of our inspection all areas seen at the practice were visibly clean and tidy. All of the patients we spoke with confirmed this. Staff confirmed personal protective equipment and hand sanitising gel was readily available and we saw that it was.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections. A legionella risk assessment had been done. (Legionella is a germ found in the environment which can contaminate water systems in buildings). We saw that the practice had an annual contract in place dated 22 October 2014 for the cleaning and disinfection of the water system at the practice.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance records and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the equipment had been tested in January 2014. We saw evidence of calibration of relevant equipment, for example weighing scales and blood pressure monitoring equipment. A certificate of calibration dated 16 June 2014 confirmed this. We saw that three digital blood pressure monitors had no label to show they had been calibrated. We told the provider this during feedback. One day after the inspection a GP sent us information to show that they had been calibrated but not labelled. To ensure this did not reoccur, the practice sent us information to show that they had put together an inventory of all equipment at the practice. Each item had been coded with a number alongside the date of calibration. To ensure that nothing had been missed and to check new equipment, the practice arranged for the contractor to calibrate all equipment on the inventory three days after the inspection.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body. We saw that Disclosure and Barring Service (DBS) checks had been completed for all clinical staff who worked at the practice. For non-clinical staff such as reception staff that may have been required to act as a chaperone; we saw that applications for DBS checks had been sent. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children.

Requires improvement

Are services safe?

Patients were cared for by suitably qualified and trained staff. There was a system in place that ensured health professionals' registrations were in date. We looked at a sample of recruitment records for clinical staff. These showed that pre-employment checks had been done to ensure that clinical staff held up to date qualifications with their governing bodies such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). This ensured that GPs and nurses were registered with their appropriate professional body and were considered fit to practice.

The practice had a recruitment policy dated 01 October 2014 that set out the standards it followed when recruiting staff. This did not align with the checks that were being done by the practice prior to the appointment of staff. We saw that the policy did not cover clinical staff and did not make reference to all of the information required to be obtained as required under Regulation 21, Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. Discussion with the practice manager confirmed this. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. We saw that this expectation for staff to cover annual leave was written in their contracts. Staff told us any staff shortfalls were discussed at staff meetings to ensure they were kept informed of what action was being taken to address this. For example, there was an administrative staff shortfall due to long term sick leave. Discussion with the practice manager confirmed this.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. For example we saw that internal fire system checks had last been completed on 18 November 2014. The fire system had been inspected by an external contractor in August 2014 and no issues were identified.

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. The practice had recognised an increased demand for appointments in the month of December. The practice manager told us an extra GP session was planned for Mondays throughout December 2014. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews, and followed up if they did not attend. Discussion with patients and a care manager for a care home that the practice provided a service for confirmed this.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest (heart stopping), anaphylactic shock (allergic reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated with regard to their likely impact on patients and the continuity of the business. Risk areas covered the computer systems, personnel, clinical and the premises. For example, risks identified included power failure, adverse weather, loss of key staff, access to the building and clinical risks such as infection, epidemic and pandemic. The document also contained relevant

Requires improvement

Are services safe?

contact details for staff to refer to. For example, contact details of the electric and gas service suppliers to contact in the event of failure of these services. A copy of this plan was held at the branch surgery. The practice manager held the contact details for all staff off site.

A fire risk assessment had not been undertaken for the practice. We told the practice about this at our inspection feedback. One day after the inspection, the practice manager sent us information that showed they had booked an external contractor to undertake a fire risk assessment on 17 December 2014. We saw records that showed staff were up to date with fire training. The practice manager told us a fire evacuation drill was due for the practice and would arrange this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment was delivered in line with current legislation and recognised best practice. The GPs confirmed they received information regarding the National Institute for Health and Care Excellence (NICE) guidelines via email and these were used as a point of reference. The practice manager told us no structured meetings were held to discuss new guidance. GPs held informal discussions after surgery most evenings where they discussed new guidance, shared information and sought advice from within the clinical team. No notes were kept of these discussions. Any patient safety alerts were added to the information discussed at the weekly meetings they already had in place with the practice manager.

Patients with long term conditions received an annual needs assessment. We saw management plans for patients with diabetes, respiratory problems and high blood pressure. Staff told us patients were encouraged to be involved with these. Patients we spoke with who had a long term condition confirmed this. The practice had introduced a system of birthday month reviews to maintain an effective system of on-going care.

Every patient over 75 years had a named GP, this included patients who lived in the care home the practice provided support to. We spoke with a representative from this home. They confirmed that needs assessments were completed when required. They told us weekly visits were made by one of the GPs. They told us it was a good practice and that the GPs worked with the staff at the homes to ensure people got the best care possible.

The practice used the Virtual Ward whenever possible to try and prevent hospital admissions for older people. (A Virtual Ward provides support in the community to people with the most complex medical and social needs. It has a structure of clinical and administrative staff that coordinates and provides care to patients in their own home).

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. The practice participated in the Quality and Outcomes Framework (QOF). The QOF rewards practices for providing quality care and helps to fund further improvements. We saw that there was a robust system in place to frequently review QOF data for asthma, chronic obstructive pulmonary disease (COPD) and diabetes and recall patients when needed. Data showed that the practice was above national average for QOF points achieved. Data also showed there were no health care outliers for this practice. (An outlier is where the value for the practice lies outside nationally set values). The practice participated in a benchmarking process through meetings with the Redditch and Bromsgrove Clinical Commissioning Group (CCG) and the NHS Area Team (AT).

The practice had a system in place for completing clinical audit cycles. An example of a completed clinical audit included an audit for coding patients with diabetes on the computer system which was undertaken in March and re-audited in November 2014. The outcome of this audit showed learning from these and changes in practice by GPs and administrative staff. For example, a meeting was held with GPs and all staff to ensure the correct code was used for patients with diabetes in order to assist with the management of this long term condition.

The GPs that worked at the practice were all involved in the management of people with long term conditions such as diabetes, heart disease and asthma. The practice manager told us one GP had an interest in orthopaedics (bone joints, muscles and ligaments) with particular interest in conditions that involved hands. He was also consulted by other GPs at the practice if they required a second opinion for these conditions. Another GP had an interest in diabetes.

GPs at the practice undertook minor surgical procedures in line with their registration and NICE guidance. For example removal of lumps such as cysts and toenails. Two GPs also did joint injections. We saw that staff were appropriately trained and carried out clinical audits on their results which were used for learning.

In their presentation the practice told us they had the highest life expectancy within the CCG area. Four of their current patients were over 100 years of age. The practice participated in research. For example, they had been involved in the Prevention of Fall Injury Trial (PreFIT). (PreFIT is the largest trial of fall prevention interventions conducted to date. The aim of this trial is to see whether

Good

Are services effective?

(for example, treatment is effective)

falls prevention can reduce fractures, not simply falls, and to provide insight into approaches which are most effective, cost-effective and acceptable to the older population).

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses that the practice saw as essential such as annual basic life support. Specialist skills noted amongst the GPs were three GPs had additional diplomas in female reproductive medicine and pregnancy, childbirth and post natal care (post childbirth). All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

The GPs were flexible with their surgery hours and ensured that all patients who required an urgent consultation were seen that day. For example, we saw that one morning surgery had not finished until 1.20pm. The practice nurses told us they were able to cover annual leave when colleagues were away. Other staff who worked in the practice were organised into teams, for example reception staff and administration staff. This enabled flexible staffing levels, whereby staff would cover any shortfalls. Staff told us that the practice manager would provide cover as and when required.

The practice had employed two part time healthcare assistants in 2014 to increase the number of appointments for blood tests and health checks. This had created more GP and practice nurse time for patients with long term conditions.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We saw that these had been done for 2014. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example a practice management course and cervical cytology updates. (Cytology is the examination of tissue cells from the body). Staff told us the practice encouraged staff to undertake courses and also funded the cost of them. This was confirmed in discussion with the practice manager.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, for the administration of vaccines and cervical cytology. Meeting minutes showed that clinical staff meetings took place on alternate months. The most recent was dated 02 October 2014.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The practice had a system that identified the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. Individual GPs were responsible for looking at their own patients' information. If they were away that day, the information was reviewed by another GP.

A GP and the practice manager told us urgent referrals were sent the same day, unless it was an evening surgery and then it would be sent the next morning. Non-urgent referrals were sent within two to three days of seeing the patient. We saw information in the complaint file that showed there had been a delay in referring two patients to other services. We saw systems for reminding GPs of follow up actions such as referrals were not used at the practice.

We found that one GPs electronic correspondence contained reports and letters that had been received up to a month prior to the date of the inspection. It was not clear

Good

Are services effective?

(for example, treatment is effective)

if this information had been reviewed by this GP. We raised this with a GP and practice manager at the inspection feedback. The GP assured us they would review this information immediately. Two days after the inspection a GP sent us information which stated that the clinical system inbox had been cleared and no urgent information was found. They told us that all of the GPs had made a decision to use the task facilities to remind them of any actions required following review of correspondence.

The practice held multidisciplinary team meetings regularly to discuss the needs of complex patients, such as those with end of life care needs or children subject to a safeguarding plan. These meetings were attended by district nurses, social workers, palliative care nurses, GPs and practice nurses. We saw that a register of patients was discussed at these meetings. The information about patients included areas such as their resuscitation status, out-of-hours information, patient and family preferences, hospice involvement and if anticipatory medicines (for example medicines for pain relief) were in place. We saw that a post death review was also undertaken. A GP showed us a form used by the practice for sharing information with the out-of-hours and ambulance service. This gave information about advance care planning, resuscitation status (DNAR) and any special notes for individual patients. Decisions about care planning were also documented on the individual patients' records. Staff felt this system worked well and remarked on the usefulness of the end of life care forum as a means of sharing important information. The provider may wish to note that alerts were not used on patients' electronic records to remind staff they were included on the palliative care register. (Palliative care is a multi-disciplinary approach that includes specialised medical care for people with serious illnesses).

Information sharing

Training records showed all members of staff had done training about information governance in 2014. This helped to ensure that information at the practice was dealt with safely with regard to patients' rights as to how their information was gathered, used and shared.

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider that enabled patient data to be shared in a secure and timely manner. The practice made referrals following discussion with the patient about their preferred choice of hospital.

The practice had signed up to the electronic Summary Care Record and this was fully operational for all patients, except those that had chosen to opt out. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information). Information for patients was available on the practice website with an opt out form should patients choose to do so.

The practice had systems in place to provide staff with the information they needed. An electronic patient record known as EMIS was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. There was a system in place to scan paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a policy on consent dated November 2014. This included information about assessment of Gillick competency of children and young adults. (This helps clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment). We also saw they had adopted the British Medical Association (BMA) guidance on the Mental Capacity Act 2005 as their policy. (In circumstances where people lack capacity to make some decisions through illness or disability health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 (MCA) to ensure that decisions about care and treatment are made in people's best interests). There was a GP lead for MCA. GPs were able to give us examples of how the guidance had been put into practice. Clinical staff told us that patients had a choice about whether they wished for a procedure to be carried out or not. For example, the phlebotomist told us how they would talk through the procedure when they took blood samples from a patient when they appeared anxious or uncertain. They told us they discussed any concerns or anxieties they had. We were told that if the patient was unsure and needed more time to consider the procedure this was agreed with them. An appointment was made for them to return to the practice to allow them more time to make their decision.

GPs told us they undertook training updates for MCA. Staff spoken with including nursing staff had not done any formal MCA training. However, they showed they had a basic understanding of the key parts of the legislation and

were able to describe to us how they implemented it in their practice. The practice manager told us they would ensure all staff completed the MCA training available through their online training programme.

We saw examples of consent forms that had been completed. However, we found two examples where patients had a family planning device fitted and no written consent had been obtained. A GP carried out an audit for consent the day after the inspection. They found that out of the 39 procedures they had done in the last three months; all minor surgery procedures had written consent, but they had only recorded verbal consent for joint injections, fitting family planning devices and cautery (the burning of abnormal tissue). The outcome from this audit was that all GPs who carried out these procedures had been informed that they must ensure that written and verbal consent was recorded for all procedures. They told us they also intended discussing this at the next practice management meeting.

Staff told us the patient always came first and they were encouraged to be involved in the decision making process. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them. GPs told us that mental capacity assessments were recorded on patients' records where applicable. We saw recorded evidence of this practice.

Staff we spoke with gave examples of how patients' best interests were taken into account if patients did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competence.

Patients with learning disabilities and patients with dementia were supported to make decisions through care plans which they were encouraged to be involved in. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw examples of records that showed care plans were in place and that reviews had been carried out. We spoke with a representative for a care home for patients with dementia that the practice provided a service for. They told us a GP undertook a mental and physical review, including medicines of all of their patients annually, or more often if the need arose.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a basic health check with a practice nurse. This included the completion of a health questionnaire, blood pressure and urine test.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, warfarin (to reduce clotting of the blood) initiation for patients with blood clots, travel advice and vaccinations and family planning. We saw patient self-care was promoted by the practice. For example, there was a blood pressure monitoring machine in place that patients could use to monitor their own blood pressure. We saw there were clear instructions to guide patients on how to operate the equipment. A range of leaflets were available in the reception and waiting room areas.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was in line with the average for the local CCG. All children aged two to four as well as children in school years seven and eight had been invited to attend the practice for a nasal flu vaccination. The practice offered a full travel vaccination service excluding yellow fever.

Both of the practice nurses were trained to carry out cervical screening and tests in the form of cervical smears. Clinical staff told us that systems were in place to ensure patients were recalled for repeat smears where any abnormalities had been found. Patients' who failed to attend for routine and follow up tests were contacted by the practice staff.

Flu vaccination was offered to all patients over the age of 65, those in at risk groups and pregnant women. The percentage of eligible patients receiving the flu vaccination was in line with the national average.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities. Similar mechanisms of identifying at risk groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

Patients with a learning disability (LD) received an annual health assessment. We saw these were usually done by one GP using a local trust format based on a nationally

Good

Are services effective?

(for example, treatment is effective)

recognised template. However, more recently the review had been less structured. The GP told us this would be discussed at the next practice management meeting with regard to restarting a more structured review format for these reviews. We saw that 12 patients were on the LD register and 11 reviews had been completed for this year. A GP told us the other review had been booked in with a GP. There were systems in place that ensured babies received a new born and eight week development assessment.

The practice offered structured reviews of all patients with severe and enduring mental health conditions with at least annual reviews of their physical, social and mental health, medicines and revision of their agreed care plan. A weekly counselling service was also available at the practice and patients could be referred to them by the GP. Patients with dementia were also offered an annual review. Patients newly diagnosed with dementia were referred to Kidderminster Early Dementia Service provided by the community trust. The Admiral Nurse (specialist dementia nurse) service was available to support families in caring for relatives affected by dementia. It also provided an educational and consultancy role to professionals. Patients could self refer to the Admiral Nurse based in Redditch or this could be done by the GP.

All of the GPs provided maternity services and they held their antenatal clinics on a Friday morning. Six week post-natal checks were done by a named GP. Eight week baby checks were done by all of the GPs.

All of the GPs offered young women a confidential and comprehensive family planning service. These GPs were also able to fit coils as part of the family planning service. The practice offered family planning advice to patients who were not registered with the practice, this included patients under the age of 16 years of age.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This was the information from the national GP patient survey published July 2014. The evidence from this source showed that the majority of patients were satisfied with the service offered by the practice. For example, data from the national patient survey showed that 79% of patients would recommend the practice. The practice was well above average for its satisfaction scores on consultations with GPs; 94% of practice respondents confirmed that the GP was good at listening to them, 93% responded that the GP gave them enough time and 96% had confidence and trust in the last GP they saw or spoke to.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 11 completed cards and with the exception of three, they were all positive about the service experienced. For the three less positive comment cards, the theme was that appointments always ran late. The majority of patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. All patients said the staff treated them with dignity and respect. We spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient told us that reception staff were sometimes abrupt. Three patients told us the appointments always ran late. However, patients told us this was because the GPs spent time with patients and listened to them.

We saw that consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us they worked to ensure patients' privacy and dignity was respected. Staff told us patients were encouraged to stand back from the reception desk and wait their turn to speak with the receptionist. This made sure that each patient was given the respect and privacy they needed. The practice manager told us that reception staff could take patients to a nearby room if the patient wished to speak with them more privately. Two of the patients we spoke with had concerns that conversations with patients at reception could be heard in the waiting room.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff told us they ensured patient's dignity was maintained by making sure the door was locked and that screens were used to enable patients to undress in private. We spoke with a manager from the care home that was supported by the practice. They described to us the caring, professional and supportive attitude of the GPs. They told us it was a good practice that listened to them and worked well with them to make sure the people they cared for received the best care.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that they felt fully informed and involved in the decisions about the care. They told us they felt listened to and supported by clinical staff and were given sufficient time during consultations to discuss any concerns. Patient feedback on the comment cards we received supported these views.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed; 82% of practice respondents said the GP was good at involving them in care decisions and 86% felt the GP was good at explaining treatment and results. These results were all above the regional average.

Staff told us that translation services were available for patients who did not have English as a first language. The check-in facilities at the practice were automated and multilingual. Staff told us that one of the staff who worked at the practice spoke Punjabi and Hindi.

Staff spoken with including nursing staff had not done any formal Mental Capacity Act (MCA) training. However, they showed they had a basic understanding of the key parts of the legislation and were able to describe to us how they implemented it in their practice. (In circumstances where

Good

Are services caring?

people lack capacity to make some decisions through illness or disability health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 to ensure that decisions about care and treatment are made in people's best interests). Staff were provided with protected time to undertake all training. Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us the patient always came first and was involved in decision making. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multi-Disciplinary Team (MDT) approach with district nurses, palliative care nurse and hospitals. We saw that the Gold Standard Framework (GSF) palliative care meetings were held quarterly and minutes were made by practice staff. We were shown the information from the last two meetings held in June and October 2014. The GSF is a practice based system to improve the quality of palliative care in the community so that patients received supportive and dignified end of life care, where they chose.

Patient/carer support to cope emotionally with care and treatment

GPs and nursing staff told us they worked closely with Macmillan nurses and the local hospice to provide care and support for patients who needed end of life care and support for relatives. Staff told us the GPs visited patients as and when required and talked to their relatives and carers at any time. Staff told us the GPs offered as much support as was needed. For example, if a call came through during surgery that a patient was in need of urgent care they would go out immediately. A GP told us they also made themselves available to families' out-of-hours based on individual need. This was confirmed through discussion with a provider of a care home they provided a service for.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or signposting to a support service.

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw the written information available for carers to ensure they understood the various avenues of support available to them.

The provider and manager from the care home the practice supported told us the GPs were excellent at providing care for patients who needed end of life care and supporting their relatives. They told us the GPs would always make themselves available for bereaved relatives if they required support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. For example the practice had a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews. A phlebotomy (blood taking) service had been established at the practice so that patients did not have to travel to the local hospital. The practice held nurse led clinics for warfarin initiation. These were clinics for patients who needed to take medicines to reduce the clotting of their blood. This also meant that patients did not have to make frequent trips to the local hospital.

The NHS Area Team (AT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff.

Feedback was given to a GP and practice manager following this inspection. This highlighted a number of areas where the practice needed to improve. The practice were very responsive with regard to action taken from areas highlighted. Within two days of the inspection, information had been sent to CQC to show how the practice had learnt from this inspection and what improvements had been made to address the areas highlighted. For example, a new system had been put into place for managing clinical reports and follow up. An equipment inventory had been produced for items that required calibration to ensure no equipment was missed when serviced. A minor surgery consent audit had been done and the outcome was acted upon. The staff accident book did not comply with Data Protection Act and a new book was ordered. A fire risk assessment was booked to be done with an external contractor.

The practice had an active patient participation group (PPG) to help them to engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. We spoke with a representative of the PPG who explained their role and how they worked with the practice. They told us that the group was predominantly retired people with approximately 50% male and 50% female members. The representative told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes in the health economy to them and listened to any concerns they had. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patient surveys. For example, the outcome of the 2014 survey showed that they had made changes to the service to increase the availability of appointments and to reduce how long patients waited to be seen at morning surgeries.

The practice usually had a low turnover of staff which enabled a good continuity of care. For example, one of the GPs had been at the practice for over 25 years. The practice manager told us staff turnover had increased recently due to career development of staff and long term sickness for one staff member. Appointments could be made with a named GP or nurse. All older people had a named GP who had overall responsibility for their care. This included the review of their conditions that might involve a home visit to see these patients. A GP told us home visits were undertaken by two to three GPs each day. Staff told us patients booked home visits in advance if they required the visit to be done by their named GP. The practice had started providing telephone appointments in addition to the telephone advice service provided by GPs. More appointments had been provided if the demand for emergency appointments increased; this included the provision of appointments that could be booked online for all GPs.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us that usually the patient was accompanied by a family member or friend who would

Good

Are services responsive to people's needs?

(for example, to feedback?)

translate for them. Staff told us they would arrange for access to a telephone interpreter if required and that information could also be translated via the website. We were told that a staff member spoke Punjabi and Hindi.

Staff told us that no homeless patients were currently registered with the practice. Staff told us however that should a homeless person need to register as a patient at the practice, this would be done so they could receive treatment. Staff told us that no one would be turned away from the practice.

The practice provided a good mix of clinical staff with regard to gender and ethnicity. Two female GPs worked at the practice and were able to support patients who preferred to see a female GP. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. For example, there were headsets available for patients with a hearing impairment for use in reception and consulting and treatment rooms. There was clear signage informing patients where to go. There was a disabled toilet and wheelchair access to and throughout the practice for patients with mobility difficulties. All consulting and treatment rooms were on the ground floor of the building. We saw the outer doors at the entrance were automatic. Staff told us they assisted patients with mobility difficulties and mothers with pushchairs with the internal doors if required. There was parking for disabled patients in the car park at the front of the practice.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable people who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

The practice had a system in place to alert staff to any patients who might be vulnerable or who had special needs, such as patients with poor mental health or patients with a learning disability. Some patients had been identified as always needing longer appointments and the system in place ensured that staff were alerted to this need as necessary.

Equality and diversity training was undertaken by staff through their online training provider. Staff we spoke with confirmed this.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients on leaflets, through information displayed in the waiting room and on the practice website.

The practice was open from 8.20am to 1pm and 2pm to 6.30pm on a Monday, Wednesday, Thursday and Friday. The practice closed at 12 noon on a Tuesday. Telephones were answered by receptionists when the surgery was closed at lunchtime. Patients could access the service for appointments from 8.20am and on line booking was also available. Most morning surgery appointments were available for booking on the day and most evening surgery appointments could be booked up to three months ahead. All patients that required an urgent medical appointment would be seen the same day. The practice offered telephone appointments with a GP on Tuesdays and Fridays from 8am to 8.30am. There was a walk in surgery at Feckenham branch surgery on a Monday, Wednesday and Friday between 2.15pm and 3.30pm. The doors to the surgery were open from 2pm. This service was for patients who lived in Feckenham, Bradley Green, Dormston, Inkberrow and surrounding villages.

Longer appointment times were made available to patients as needed, such as patients with poor mental health and long term conditions. Patients we spoke with were aware they could book longer appointments with a GP if required. The practice did not provide extended hours as part of their contract with NHS England.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patient surveys. For example, the outcome of the 2014 survey showed that they had made changes to the service to increase the availability of appointments and to reduce how long patients waited to be seen at morning surgeries. Three patients we spoke with and three patients who completed comment cards told us the appointments always ran late. However, patients also told us this was because the GPs spent time with patients and listened to them.

One patient commented that they had to wait up to two weeks to see their GP of choice. Others told us they had always been able to access appointments when required. Patients told us they had difficulty getting through to the practice in a morning to make an appointment. A GP told us they were aware that this was an issue and were reviewing their current telephone system with regard to the number of calls that could currently be in the queue waiting to be answered.

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. There was a designated responsible person who handled all complaints in the practice.

We looked at the complaints log for the last 12 months and found that these all handled and resolved to the satisfaction of the individual patient.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified. The practice manager told us lessons were learnt from individual complaints had were acted upon. For example, concerns raised about staff attitudes. We saw this was discussed with staff at a practice meeting. Staff had also undertaken customer care training through their online training programme. The provider may wish to note that a complaint tracker was not used by the practice as an overview for complaints received.

The GPs and the practice manager told us that complaints were discussed formally at the bi-monthly management meetings. We saw that complaints and compliments were a standard agenda item for these meetings. We saw that the outcome and learning from complaints was then shared with the staff team at team meetings. Staff told us they were aware of what action they should take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans.

Staff told us they felt able to raise any concerns and would feel comfortable approaching any staff at the practice. The practice had a whistle blowing policy and procedure in place. Staff confirmed knowledge of this and confirmed they would use it if all other attempts to resolve concerns had failed or they felt unable to raise concerns.

We saw that information was available to help patients understand the complaints system. The process was described in patient leaflets and on the practice website.

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 had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and values were set out in a practice document. This stated the practice was committed to providing a full range of high quality primary care, through the delivery of services which were timely, considerate and responsive to the needs of their patients.

The practice placed high values on communication with their patients as they felt this would help patients to understand their present problems and improve their outcomes for long term health. The practice valued continuity for patients, they cared for the whole family, assisted patients to access health and social care services and worked with their patients to improve both their service and others. We spoke with five members of staff and they were all familiar with the values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at 13 of these policies and procedures. All 13 policies and procedures we looked at had been reviewed annually and were up to date.

The practice participated in the Quality and Outcomes Framework (QOF). The QOF rewards practices for providing quality care and helps to fund further improvements. We saw that there was a robust system in place to frequently review QOF data for asthma, chronic obstructive pulmonary disease (COPD) and diabetes and recall patients when needed. Data showed that the practice was above national average for QOF points achieved. Data also showed there were no health care outliers for this practice. (An outlier is where the value for the practice lies outside nationally set values). The practice participated in a benchmarking process through meetings with the Redditch and Bromsgrove Clinical Commissioning Group (CCG) and the NHS Area Team (LAT).

The practice had a system in place for completing clinical audit cycles. An example of a completed clinical audit included; an audit for coding patients with diabetes on the computer system which was undertaken in March and re-audited in November 2014. The outcome of this audit showed learning from these and changes in practice by GPs and administrative staff. For example, a meeting was held with GPs and all staff to ensure the correct code was used for patients with diabetes in order to assist with the management of this long term condition.

The practice had arrangements for identifying, recording and managing risks. We saw a number of protocols and risk assessments. For example, spillages, needle stick injury and risks to the business. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Staff showed us risk assessments that had been completed for risks identified such as needle stick injuries.

Leadership, openness and transparency

There was a clear and visible leadership and management structure in place. For example one of the GP partners was the lead for safeguarding and the Caldicott Guardian. (A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service user information and enabling appropriate information sharing). We spoke with staff from different teams and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. There was evidence of strong team working and support for each other. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with one of the GPs weekly and all of the GPs bi-monthly and information from these meetings was shared with staff. Staff told us that the GPs, practice manager and team leaders were very supportive.

Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through individual appraisals. We spoke with a GP who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Are services well-led?

Good

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

We saw from minutes that a range of meetings were held at varying frequency. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at the meetings.

The practice manager had lead responsibility for human resources policies and procedures supported by the GP partners. We reviewed a number of policies, for example the recruitment and induction policies which were in place to support staff. Staff we spoke with knew where to find the policies if required.

We found the practice to be open and transparent, and prepared to learn from incidents, near misses and audit and inspections by external agencies. Management meetings were held where these were discussed. Lessons learned from these discussions were shared with the clinical team. We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken. However, we found national safety alerts for medicines had not been followed thoroughly enough by the GPs. One day after the inspection a GP sent us information to show that appropriate action had now been taken by the practice for all medicines subject to the identified safety alerts.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had an active patient participation group (PPG) to help them to engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. We spoke with a representative of the PPG who explained their role and how they worked with the practice. They told us that the group was predominantly retired people with approximately 50% male and 50% female members. The representative told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes in the health economy to them and listened to any concerns they had.

The practice had gathered feedback from patients through patient surveys and complaints received. A locked suggestions box that was managed by the PPG members only was available for patients to leave comments for consideration at meetings. A notice board dedicated to the PPG was available in the waiting room to enable feedback to the wider patient population. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patient surveys. For example, the outcome of the 2014 survey showed that they had made changes to the service to increase the availability of appointments and to reduce how long patients waited to be seen at morning surgeries. A PPG representative told us they had discussed the survey results at a meeting in March 2014. The priorities for action were decided and actioned. For example, the practice recruited two part time healthcare assistants to undertake clinical duties. This helped create more availability of appointments with the GPs and practice nurses. They were also encouraging patients to attend birthday reviews. A mid-morning break in the surgery appointments was added as a 'catch up' period to attempt to reduce the waiting times at the surgery.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified. The practice manager told us lessons were learnt from individual complaints had were acted upon. We saw that five comments had been made on the NHS Choices website for 2014. These contained a mix of positive feedback and some less positive feedback. We saw that the attitude of staff was a theme for these complaints. We saw this was discussed with staff at a practice meeting. Staff had also undertaken customer care training through their online training programme.

The practice had gathered feedback from staff through staff meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues they had with colleagues and the management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Discussion with staff confirmed this. Staff told us that the practice was very supportive of training and that they were given protected time to undertake training.

Are services well-led?

Good

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

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records for significant events for 2013 to 2014 were made available to us. Staff told us they were responsible for completing significant event forms, and significant event analysis was carried out each time there was a patient safety incident. The practice manager told us learning points from significant events and complaints were shared with staff at practice meetings. Staff told us they were informed of the outcome from these and debriefed through staff meetings.

Feedback was given to a GP and practice manager following this inspection. Within two days of the inspection, information had been sent to CQC to show how the practice had learnt from this inspection and what improvements had been made to address the areas highlighted. For example, a new system had been put into place for managing clinical reports and follow up. An equipment inventory had been produced for items that required calibration to ensure no equipment was missed when serviced.