The Glebeland Surgery

Quality Report

The Glebe
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Date of inspection visit: 30 October 2014
Date of publication: 05/02/2015

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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of The Glebeland on 30 October 2014. We found that The Glebeland provided a good service to patients in all of the five key areas we looked at. This applied to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to their patients.
- The practice was proactive in helping patients with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- The practice was clean and hygienic and had robust arrangements for reducing the risks from healthcare associated infections.
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals.
- The practice had a settled and well trained team with expertise and experience in a wide range of health conditions.
- The practice provided flexible and responsive services, (including a dispensary) in a rural area where there was limited public transport.
- The practice provided a caring and responsive service to a significant number of patients living in four local care homes and to pupils at a residential school.

There were areas where the practice needs to make improvements.

The practice should:

- Introduce a more comprehensive range of clinical audits to monitor and improve performance and contribute to staff learning.
- Develop their systems system for capturing, recording and learning from significant events to make these more comprehensive and robust.
- Ensure all GPs working at the practice have completed up to date safeguarding training.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. The practice shared information with staff about significant events and was committed to providing a safe service. The practice assessed risks to patients and managed these well. The practice took its responsibilities for safeguarding adults and children seriously and had suitable arrangements for reporting any concerns they identified.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average nationally. Patients' care and treatment took account of National Institute for Health and Care Excellence (NICE) guidelines. The practice assessed patients' needs and planned and delivered their care in line with current legislation. Referrals to other health care professionals were made in a timely way. The practice was proactive in the care and treatment provided for patients with long term conditions such as asthma and diabetes and regularly audited some areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice in the mid-range or higher than others in England for several aspects of care. Patients told us they were treated with kindness, dignity and respect. They felt that they were treated as individuals and that they were involved in care and treatment decisions. The practice provided patients with information to help them understand the care available to them. Staff were aware of the importance of confidentiality. Patients told us that their GP was caring and reassuring, particularly when discussing possible serious illness or when patients were dealing with challenges in their lives.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these are identified. Patients reported good access to the practice

Summary of findings

and said that urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system and we saw that the practice responded quickly and positively to issues patients had raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had an open and supportive leadership and a clear vision to continue to develop and improve the service they provided. The partners and practice manager provided supportive leadership and staff felt supported. Whilst whole team meetings were only held annually the individual teams of staff met regularly to review the part they played in the delivery of care and the management of the practice. The practice had systems for ongoing daily and weekly communication with staff. The practice valued the views of staff and patients and were looking into re-starting a Patient Participation Group. There was evidence that the practice had a culture of learning, development and improvement.

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

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and GPs and practice nurses visited patients at home if they were unable to travel to the practice for appointments. The practice was in the process of delivering its flu vaccination programme. The practice provided a responsive service to patients living in local care homes.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions received regular health checks and had plans in place in the event of their condition deteriorating.

Patients whose health prevented them from being able to attend the surgery for appointments were visited at home. Patients told us they were pleased with the support they or their family members received to help them manage their health.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held childhood vaccination clinics for babies and children. Childhood flu vaccinations were also provided. A midwife came to the practice every week to see pregnant women. The practice provided a family planning service. The GPs and nurses worked with other professionals where this was necessary, particularly in respect of children who may be living in vulnerable circumstances.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age people, recently retired people and students. The practice had arrangements for people to have telephone consultations with a GP and provided an extended service on an 'as required' basis for patients unable to attend the practice during main practice opening hours. The practice provided NHS health checks for patients between the ages of 40 and 74. Students were offered Meningitis C vaccinations before they started at college or university.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a learning disability

Summary of findings

register and all patients with learning disabilities were invited to attend for an annual health check. Staff told us that the practice did not have any homeless people or traveller families currently registered at the practice. Staff at the practice worked with other professionals to help ensure people living in difficult circumstances had opportunities to receive the care, support and treatment they needed. The staff team were aware of their responsibilities regarding information sharing and dealing with safeguarding concerns. The practice worked in partnership health, social care and education professionals and took into account the Mental Capacity Act 2005 when considering patients' care and treatment needs.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had a register of people at the practice with mental health support and care needs and invited them to attend for an annual health check. A counselling service was available at the practice two hours each week. The practice staff were mindful of the need to work in a supportive and flexible way with patients with mental health needs.

The practice was proactive in dealing with the complex needs of people who were living with dementia and provided a responsive and caring service to local care homes. They were about to take part in training to become 'Dementia Friends' a national initiative by the Alzheimer's Society to raise awareness and create 'dementia friendly communities'. The practice worked in partnership with care home staff and took into account the Mental Capacity Act 2005 when considering patients' care and treatment needs.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 42 Care Quality Commission (CQC) comment cards patients had filled in and two additional comment slips provided by the practice when our cards had all been used. On the day of our inspection we spoke with eight patients. Data available from Public Health England for 2012/13 and from the NHS England GP patient survey in 2013/14 showed that the practice scored in the middle range or above nationally for satisfaction with the practice.

Patients were positive about their experience of being patients at The Glebeland. They described a caring and responsive service where they were treated with compassion and understanding. Patients commented that their GP listened to them and treated them with respect. We heard from a number of patients with long term health conditions who described receiving the care, treatment and support they needed to help them manage their conditions.

Most of the comment cards included very complimentary statements about the attitudes of all members of the practice team. Patients told us that they were able to get appointments when they needed them whether this was in an emergency or for routine treatment.

Many patients commented that in their experience the practice was always clean and hygienic.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve

- Introduce a more comprehensive range of clinical audits to monitor and improve performance and contribute to staff learning.
- Develop their systems system for capturing, recording and learning from significant events to make these more comprehensive and robust.
- Ensure all GPs working at the practice have completed up to date safeguarding training.

The Glebeland Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP Specialist Advisor and an Expert by Experience (a person with direct personal experience of using health and care services).

Background to The Glebeland Surgery

The Glebeland is situated in a residential area in the Worcestershire village of Belbroughton near Redditch. It has around 4,400 patients. There has been a GP practice called The Glebeland in Belbroughton since the 1960s. One of the current GPs had joined a relative at the practice in 1991. The relative retired in 1995 and another GP then joined. Both GPs had therefore been at The Glebeland for over 20 years.This gave the practice a strong sense of continuity and community links. In 1994 the practice moved from a small cottage to purpose built premises and the number of patients had increased from 2,400 to the current 4,400. The practice is a dispensing practice with a dispensary in the building.

The practice is in an area with low social and economic deprivation. The practice has a higher proportion of patients between 40 and 70 and those over 85 than the England average. The practice provides care to people in four local care homes and a residential school. It has 11% more of its patients living in care homes than the England average. The number of patients between 20 and 40 is lower than the England average as is the number of children under four years old.

The practice has two partners, one male and one female, both of whom work full time. The practice has two part time practice nurses and a part time phlebotomist (a person trained to take blood). The clinical team are supported by a full time practice manager, and a team of five part time administrative and reception staff. The practice dispensary is staffed by one full time and two part time dispensing staff.

The practice is a teaching practice which provides placements for medical students who have not yet qualified as doctors. The practice did not have any students on placement at the time we did this inspection.

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

This was the first time the CQC had inspected the practice. Based on information we gathered as part of our intelligent monitoring systems we had no concerns about the practice. Data we reviewed showed that the practice was achieving results that were in line with the England or Clinical Commissioning Group average in most areas and higher in some.

The practice does not provide out of hours services to their own patients. Patients are provided with information about local out of hours services which they can access by using the NHS 111 phone number.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check

whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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 this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Redditch and Bromsgrove Clinical Commissioning Group (CCG), NHS England Local Area Team (LAC) and Worcestershire Healthwatch. We carried out an announced visit on 30 October 2014. Before our inspection we sent CQC comment cards to the practice. We received 42 completed cards (and two extra comment slips provided by the practice when all the CQC ones had been used). These gave us information about those patients' views of the practice. On the day of the inspection we spoke with eight patients at the practice and with a range of staff (one of the GP partners, a practice nurse, the practice manager, reception staff and members of the dispensary team).

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)

Good

Are services safe?

Our findings

Safe Track Record

The GP we met confirmed the practice had never had any major adverse events, for example they had never had any serious complaints or had concerns taken to the General Medical Council (GMC). They were confident that they had a sound track record in respect of safe care and treatment.

The practice had a system for reporting, recording and monitoring significant events including a structured reporting form to record the details of individual events. All the staff could use this to report any concerns they identified. When an incident or event was recorded the practice stored the details in a file which was available for staff to refer to. The practice had recorded events over several years but had not collated the information to provide an overview of any trends or improvements required.

Learning and improvement from safety incidents

The practice recorded most significant events and discussed these within the practice team but they did not always make a record of these discussions or carry out a full significant event analysis (SEA) to help support learning from what had happened. During discussions with the GP and practice manager we heard they had recently had a total computer failure which had been out of their control and made some parts of the system unavailable for a week. They had dealt with the matter efficiently at the time and taken prompt action to work with engineers to have the fault put right but had not done an SEA. This would have provided an opportunity to review what had happened, how they had dealt with it and identify whether, in a similar situation in the future they could do anything differently. The practice manager showed us some guidance notes which provided a structure for auditing significant events that the practice had not yet implemented.

Staff at the practice described an approach that encouraged openness and learning when things went wrong rather than attributing blame. They told us that because the practice was small there were a lot of immediate and direct discussion about events and changes but acknowledged the benefits of developing their records to support this.

The practice was able to give us examples of changes they had made which had not necessarily been recorded as SEAs. For example they had changed their system for organising referral letters after one was sent for the wrong patient to make sure this could not happen again.

National and local safety alerts arrived at the practice by email and the practice manager checked and then circulated these to all the GPs and practice nurses. They saved these on the practice shared drive so that there was an audit trail of the information and access to them for reference in the future.

The practice manager compiled a weekly practice newsletter for staff which they used to make sure important information, including safety related topics, was shared promptly with the whole staff team.

Reliable safety systems and processes including safeguarding

The practice had a chaperoning policy and a practice nurse told us that all patients were asked if they wanted a chaperone present. Information about the availability of chaperones was displayed in the waiting room. Chaperone presence during appointments was always provided by the practice nurses.

The practice had a lead GP for safeguarding and staff we spoke with knew who this was. Staff we spoke with had a good understanding of their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect. The practice had a safeguarding policy which included information about identifying and reporting abuse and neglect. Information about important contact numbers for the multi-disciplinary child and vulnerable adult safeguarding teams was available for staff to refer to. The practice had clear systems which made sure that relevant staff were aware of any child known to be at risk or who was in the care of the local authority.

The GP who was the safeguarding lead did annual level three safeguarding training updates arranged through the NHS England local area team. This was the safeguarding training level expected for their lead role. The practice manager informed us that the other GP had not completed annual safeguarding training updates. The nurses did level two on-line safeguarding training. Non-clinical staff had either completed or were doing safeguarding training on-line.

Good

Are services safe?

The practice held monthly meetings with the health visitor team. These were mainly used to discuss families and children and in particular any discuss child safeguarding cases. The practice nurse told us they also took part in these meetings in specific circumstances including when a child was not brought to the practice for its childhood vaccinations. In situations where there was concern about a child's safety the practice logged the relevant health visitor's contact information in the child's notes so these were readily available if needed.

The GP we spoke with gave us examples of situations where they had needed to make safeguarding referrals. These had related to adults and children where practice staff had identified concerns and made referrals to the relevant health and social care professionals so that steps could be taken to ensure the well-being and safety of the patients concerned.

The practice had a whistleblowing policy which included information about the rights and responsibilities of staff and patients. The document included information about contacting the General Medical Council (GMC) and CQC if someone wanted to raise a concern about patient safety.

Medicines Management

The Glebeland is a dispensing practice with its own pharmacy staffed by trained pharmacy assistants working under the supervision of the GPs. The dispensary was clean, tidy and well organised and patients and local care homes told us it provided an efficient and much valued service.

The prescribing arrangements at the practice gave patients a variety of options for obtaining their repeat prescriptions. There was a process for prompting patients who needed to have their medicines reviewed by a GP and this was done at suitable intervals depending on the specific requirements relating to individual medicines. This was monitored by the dispensary staff who communicated closely with the GPs. This helped to ensure that patients whose health needed to be monitored had the reviews and checks they needed before repeat prescriptions were issued.

Staff told us that when GPs visited patients at home they usually returned to the practice to complete a prescription and send it to the pharmacy. The GPs also had prescription pads so that they could write a prescription at a patient's home if needed. The practice had a record of these prescription pads including the serial numbers so that there was an audit trail of the prescriptions each GP had.

We saw evidence that staff monitored and recorded the temperatures of the fridges where vaccines and other temperature sensitive medicines were stored. One of the practice nurses was responsible for ordering vaccine stocks and for checking stock and expiry dates. We found that whilst they had an organised system for doing this they had not been keeping a record of their checks. Following the inspection the practice confirmed that they had introduced a recording system which provided them with written confirmation of all the checks they did. They confirmed that their system also enabled them to easily cross reference any medicines safety alerts to check whether they needed to take action. The nurse we spoke understood their responsibilities in respect of national guidance for giving vaccines to patients.

We looked at the arrangements in the dispensary. One of the GP partners was a member of the board of the Dispensing Doctors Association and the practice took part in the Dispensary Services Quality Scheme. This scheme is linked to the practice contract to reward practices for high quality dispensing services. The scheme sets out clear expectations and standards for this. One expectation is that dispensing staff should be competent to a standard equivalent to National Vocational Qualification (NVQ) level two in pharmacy services. Two of the three dispensary staff at the Glebeland had completed NVQ level three training in pharmacy services. The dispensary team was well organised and had effective stock control systems to make sure that stock levels were tightly controlled. All incoming stock was logged as were all medicines dispensed to patients or disposed of. An automatic ordering system was used to order replacement stock. The practice had appropriate systems for making sure that patients' prescriptions were signed by a GP before medicines were dispensed.

We looked at the arrangements for controlled medicines in the pharmacy. Controlled medicines require special storage arrangements and additional checks because of their potential for misuse. We saw that the storage, record keeping and stock control for these medicines was well managed in accordance with legislation.

Cleanliness & Infection Control

Good

Are services safe?

A number of patients who filled in our comment cards specifically commented on the high standard of hygiene and cleanliness at the practice. The practice was visibly clean and tidy when we inspected. General cleaning of the premises was done by a cleaner employed by an agency. We saw charts in each room to confirm what had been cleaned by them. Clinical equipment was cleaned by the practice nurses and we saw that they had task lists as prompts to make sure all the necessary cleaning was done. The privacy curtains around the couches in clinical rooms were washed at home by one of the GPs and staff confirmed that this was done in line with requirements about the temperature of the water.

Cleaning equipment and products were kept secure. Specific equipment and products were available to deal with any bodily fluids that might need to be cleaned. We saw that there was a good supply of personal protective equipment, such as disposable gloves and aprons, for staff to use.

The practice had a written infection prevention and control (IPC) policy and risk assessment and an up to date legionella risk assessment. We saw evidence that the practice manager checked and recorded water temperatures each month. Legionella is a bacteria found in the environment which can contaminate water systems in buildings.

The practice had a contract with a specialist company for the collection of clinical waste and had suitable locked storage for this and 'sharps' awaiting collection.

There was a sharps injury procedure so staff had information about the action to take if they accidentally injured themselves with a needle or other sharp medical device. Staff at the practice were all offered Hepatitis B vaccinations to protect them against the risk of contracting this virus.

The practice carried out minor surgery including dealing with minor injuries and joint injections and was approved for the removal of basal cell carcinoma (the most frequently found type of skin cancer). The practice used only single use disposable instruments for any minor surgery it did to reduce the risk of cross infection.

Equipment

In our discussions with staff we established that the practice had the equipment they needed for the care and treatment they provided. This included some items of equipment to enable patients to have ongoing tests and checks done at home such as blood pressure monitoring and testing blood clotting.

We saw evidence that equipment was maintained and re-calibrated as required. The practice had a contract for this with a specialist company who visited the practice annually and carried out repair work at other times when needed. Portable electrical equipment was tested and fire safety tests and checks were recorded.

Staffing & Recruitment

The practice had a very low turnover of staff. Only one member of staff had been employed there for less than three years. The practice had a written recruitment procedure based on current legislation and this described the checks that can help practices make sure the staff they recruit are suitable. The policy included information about how to decide which staff would require a check to be carried out through the Disclosure and Barring Service (DBS). DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable.

The practice had carried out DBS checks when clinical staff were employed to work at the practice but not for reception and administrative staff or for staff who worked in the dispensary. This was in line with their policy but they had not recorded how they had assessed the different responsibilities and activities of staff to determine if they were eligible for a DBS check and to what level. The practice manager informed us that were considering applying for DBS checks for all staff in the new year at the same time as renewing the clinicians' checks.

The overall staffing levels and skill mix at the practice ensured that sufficient staff were available to maintain a safe level of service to patients. Because the practice had only two partners they needed to use locums to cover annual leave and sickness. They did not use an agency for this because they preferred to use GPs who they knew well and had worked at the practice before. They therefore used a small number of specific locums who worked for them regularly. The practice manager confirmed that they checked that the locums were registered with the General Medical Council and were on the NHS England performers list as well as making sure that they had a DBS check.

Good

Are services safe?

The practice manager showed us that they had a system to check the GMC website regarding the GPs' registrations and also the practice nurses' Nursing and Midwifery Council registrations twice a year.

There were two part time practice nurses. One of these had done diploma level extended training in respect of COPD and asthma. The other had joined the practice recently and was the lead for diabetes. They had done a three day intensive course for diabetes and were booked to start a diploma level course early in 2015.

Monitoring Safety & Responding to Risk

The practice took health and safety seriously. We saw evidence that a range of up to date risk assessments were available. These included topics such as electrical safety, fire safety, infection prevention and control, furnishings and general maintenance and legionella. We saw that there was a risk assessment for each room at the practice and evidence that water temperatures were checked and recorded every month.

The practice team explained that because of the location and size of the practice they knew patients well and were aware of those patients who may be at risk, living in difficult circumstances or whose health was of concern. The practice used the computer system to alert GPs and nurses to patients with long term conditions, mental health needs, dementia or learning disabilities. Reception staff could also refer to the system to identify when a patient was likely to need a longer appointment. The practice gave us an example of how they responded to the needs of patients in ways which recognised their specific individual needs. This included patients who might need longer appointments or to be seen at short notice.

The practice had arrangements for direct contact with the police if they required support in an emergency.

Arrangements to deal with emergencies and major incidents

All staff at the practice completed Cardiopulmonary Resuscitation (CPR) training every year. The practice computer system included an instant messaging alert system. Staff explained that they could use this in the event of a medical emergency in the building to send a message to GPs and nurses asking for urgent assistance.

The practice had oxygen, a defibrillator and emergency medicines available for use in a medical emergency at the practice. We saw evidence that staff checked these regularly to make sure they were available and ready for use when needed.

We saw evidence of fire safety checks and tests including fire alarms and annual fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and nurses showed that that they were aware of and worked to guidelines from local commissioners and the National Institute for Heath and Care Excellence (NICE) about best practice in care and treatment. The practice manager received these and circulated them to all the GPs and nurses. The practice could give us examples of changes they had made to practice based on NICE guidance. For example they had identified those patients taking warfarin, (a medicine to reduce blood clotting) who would be suitable and likely to benefit from changing to a different type of medicine for this. Data available to us showed that the practice had high achievement levels for the Quality and Outcomes Framework (QOF). QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements.

Management, monitoring and improving outcomes for people

Members of the team described a well organised approach to making sure that people with long term conditions were reviewed regularly. One of the practice nurses took a lead in supporting patients with respiratory conditions such as asthma chronic obstructive pulmonary disease (COPD) and had done extended training at diploma level regarding this role. The practice nurse who had previously led on diabetes care had left. The practice had replaced them with a new practice nurse who had recently done an intensive diabetes course. They were also booked to complete a diploma level course early in 2015.

The practice reviewed all patients with diabetes twice a year and patients with asthma annually. Children with asthma were reviewed twice a year. The practice provided a 24 hour blood pressure monitoring facility for patients where this was needed. The practice nurse explained that patients with COPD and asthma were asked to come back in one year. If they did not make an appointment the practice followed this up with a reminder letter when they were two months overdue. The dispensary team also played a role by alerting the GPs when patients requested repeat prescriptions for inhalers outside of their review period. The practice nurses visited patients with long term conditions at home if their health and/or their mobility prevented them from coming to the practice for their appointments so that they were not disadvantaged.

A practice nurse described how they had recently spent a whole afternoon at a local care home to do the annual checks for patients with long term conditions and to give flu vaccinations. They told us that they had really enjoyed this because they knew all of the patients there and it had been made into an event.

New patients were asked to fill in a questionnaire about their health and were all offered the opportunity of an appointment with a practice nurse if they wanted one. Any patient on medicines or with a long term condition would be booked in for a 20 minute appointment with a GP.

The practice knew how many of their patients had mental health problems and encouraged those patients to have an annual check of their physical health. The pharmacy staff, GPs and practice nurses worked together to ensure that these patients' medicines were reviewed as necessary and to follow up any patients who had not arranged appointments for this at the appropriate time. Initially the practice either wrote to patients or sent them a text message and one of the GPs then contacted patients by phone if they had still not been in touch.

The practice had a higher than the national average number of older patients and those over 75 were allocated specifically to one or other of the two GPs so that they had a named GP. However, the reality was that as both GPs had been at the practice a long time most patients knew both of them well. The 50/50 split of patients had been organised alphabetically but some patients had asked for the other GP and the practice manager told us they had accommodated this.

One of the GPs had a long standing interest in the care and treatment of people living with dementia illnesses. This was reflected in the practice's diagnosis results for dementia in the Quality and Outcomes Framework (QOF) being double the national average. QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. The practice had booked training with the Alzheimer's Society to enable all of the staff to become a 'Dementia Friend'. The Alzheimer's Dementia Friends scheme is designed to raise awareness and create "dementia friendly communities". Staff at the

practice were also able to attend training about dementia at one of the care homes supported by the practice. We spoke with the manager of that care home who told us that the practice was very aware of the needs of patients at the home and were supportive regarding the care and treatment needs of patients living with dementia. They told us that the practice was proactive in referring patients for specialist input.

The GP we spoke with told us that whilst they and the other GP did not have a structured peer review process they frequently discussed and reviewed patients' care and treatment needs. The practice did not have a fully established system for completing clinical audit cycles, a process by which practices can demonstrate ongoing quality improvement and effective care. At the time of our inspection there were two ongoing audits taking place at the practice. One of these was for minor surgery. This included a survey form for patients to follow up on the outcome of their procedure and whether or not they had had an infection afterwards. The other related to cervical smears and was linked to the practice nurse's professional registration with the Nursing and Midwifery Council.

Staff at the care homes and residential school provided us with several examples of specific situations where the practice had been proactive in making sure that patients received the care, support and treatment they needed. They told us that the GPs had followed through to discover why patients were unwell and had make sure that the support and care from other health professionals such as district nurses, speech and language therapists and dementia specialists was provided.

Effective staffing

The GPs and nurses at the practice had a wide range of knowledge and skills. The clinicians' knowledge and skill was updated with ongoing accredited training and in-house training. The practice manager made checks twice a year regarding the registration of the GPs and practice nurses. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the GMC can the GP continue to practice and remain on the performers list with NHS England. The GPs at the practice received internal appraisal in addition to the external appraisal necessary to complete the revalidation process. Other members of the staff team also reviewed annual appraisal which the GPs and practice manager shared responsibility for.

Staff received ongoing training at the practice. Some of this took place during the practice's annual training day. However, if something arose in between those days, training was arranged as necessary. Staff were able to access training relevant to their roles and responsibilities. For example the practice nurses had lead roles in respect of long term conditions such as diabetes and asthma and had completed or were about to start extended training in respect of these. One of the reception staff showed us the list of on-line training modules they and other reception staff were working through. The list included equality and diversity, child and adult safeguarding, infection control, being open and complaints, information governance and the Mental Capacity Act 2005. The GP told us that they financed training for staff and provided protected time for this.

Staff could ask for discussions at any time and did not have to wait for scheduled supervision or appraisal. There was a specific structure so that all staff had supervision and annual appraisal with the most appropriate member of the team. This had been in place for a number of years.

Working with colleagues and other services

The practice told us they worked in partnership with other services such as Macmillan nurses, district nurses and health visitors. They recognised the importance and value of this, particularly for patients with long term conditions or needing end of life or palliative care. The practice took part in quarterly palliative care meetings with other health professionals to discuss patients receiving palliative care.

A counsellor funded by the Clinical Commissioning Group (CCG) was at the practice for two hours a week and patients could be referred direct to them by the GPs.

Several patients informed us that the practice had made referrals to hospitals quickly and had been proactive in making sure people received the tests and treatment they needed. Staff at the care homes and residential school confirmed that the GPs worked in partnership with them and respected their views about patients' needs.

The GP we spoke with told us that they used the 'virtual ward' facility regularly to help to avoid patients having to be admitted to hospital. 'virtual wards' provide hospital led care and treatment direct to patients in their own homes. They said this was particularly beneficial when patients' health needs were also linked with social support problems.

Good

Are services effective?

(for example, treatment is effective)

Information Sharing

The practice had a data protection policy and was registered with the Information Commissioner. The practice manager showed that they were aware of the importance of robust systems to maintain the security of patients' information.

One of the two GPs was responsible for checking all test results and did this each morning between 8am and 9am. When one was not at work the other GP did this. The practice nurse told us that the GPs used the computer system 'tasks' facility to request follow up appointments with the nurse team when test results reflected the need for this. Each GP had one session each week blocked out to provide them with time to follow up referrals and tests and do other administrative tasks.

The practice was about to start using the Summary Care Records system to make the sharing of information between health professionals easier, particularly in emergency situations and out of surgery hours. The practice manager told us that the computer software for this had been set up in preparation and they were booked on a training course the following week. Patients had been consulted about their records being made available in this way. A small number had declined and this had been recorded in their individual records.

The practice had a clear system for checking, recording and storing information sent to them by other health professionals including the out of hours service. The practice had systems in place for making information available to the out of hours and ambulance services about patients with complex care needs, such as those receiving end of life care. The information they shared in this way included whether or not a person wished to be resuscitated if they had a cardiac arrest. The GP we spoke with explained that they had also asked the out of hours service to contact the GPs direct by telephone if they had concerns about a patient.

The practice recognised the importance of confidentiality and of complying with data protection legislation. Staff (including any locum GPs) were required to sign to confirm they had read and understood the confidentiality and data protection policies. The practice had separate confidentiality policy describing their approach to teenagers' right to confidentiality in respect of contraception if they were assessed as being Gillick competent. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

The practice was alert to the difficulties of assuring patients about confidentiality because of its location in a village where many people, including practice staff, knew one another socially. The practice manager described a zero tolerance approach to breaches of confidentiality. The practice had written consent forms for patients to fill in if they wanted a member of their family to have information shared with them. Reception staff were aware that they must not share any information with family members without one of these forms being in place.

Consent to care and treatment

In situations 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.

The practice had a written policy about consent. This included information about the MCA and a form to use to help clinicians needing to assess a patient's capacity to be involved or not in decisions about their care and treatment. The policy provided clear guidance about how health professionals should meet the requirements of the MCA including how to approach making best interest decisions with others when patients do not have capacity.

The practice's consent policy also referred to Gillick competence. We spoke to a practice nurse who clearly described how they applied their knowledge of this to their work with children and young people. For example, when students came to the practice for their meningitis C vaccinations.

The GP gave us examples of situations where they had made or been involved in multi-disciplinary decisions about patients health and welfare needs.

Staff we spoke with at the four care homes and the residential school supported by the practice gave us a number of examples which showed that the GPs understood and worked in accordance with the

Good

Are services effective?

(for example, treatment is effective)

requirements of the MCA. The examples showed that the GPs had respected the patients concerned, upheld their human rights and acted in their best interests according to the individual circumstances.

Health Promotion & Prevention

The practice had an informative website and a wide range of information about various health and care topics in the waiting room and reception where patients could see them. The GPs and nurses also printed information for patients direct from the NHS computer system. This helped to ensure patients always received the most up to date information which could be printed in languages other than English if needed. There was a screen in the waiting room which provided rolling information about a wide range of health conditions. We saw information about the support and advice available regarding violence and sexual abuse displayed in the toilet area.

The practice had been providing NHS health screening checks for patients between 40 and 74 years of age for the last two years. Shingles vaccinations were available for people aged 70 or 79. Clinics for childhood immunisations were held and six week checks were carried out for babies. Cervical screening was also provided and the practice had achieved screening rates which were at the high end of the middle range nationally Data available for 2013/14 showed that the practice was also in the middle range nationally for various other health checks including those for patients experiencing poor mental health.

The practice was in the process of working though all of its patients who should receive flu vaccinations. The practice manager explained that at the start of 2015 they would do a search on their system to identify any patients who had not had their vaccine and contact them to encourage them to do so. The practice was providing meningitis C vaccinations for students.

The practice was proactive in providing annual health checks for people with learning disabilities, mental health needs and in monitoring the care needs of patients with long term conditions. This work was reflected in their good results for the Quality and Outcome Standards Framework (QOF). QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. The practice had been using text messages to remind patients with long term conditions about their follow up appointments for the last two and a half years. The dispensary staff also worked closely with the GPs to help monitor people's repeat prescription requests, particularly when they were overdue for a routine check.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We received 42 completed cards (and two extra comment slips provided by the practice when all the CQC ones had been used). During the inspection we met and spoke with eight patients. The information we gathered gave us a positive view of the care and treatment patients felt they received. Data available from Public Health England for 2012/13 and from the NHS England GP patient survey in 2013/14 showed that the practice scored in the middle range or above nationally for satisfaction with the practice.

Patients were positive about their experience of being patients at The Glebeland. They described a caring and responsive service where they were treated with compassion and understanding. Patients commented that their GP listened to them and treated them with respect. Some mentioned that the GPs were interested in their views about their health and in any research information they asked the GP to consider.

All of the information patients provided about respect for their privacy, dignity and confidentiality was positive. Patients told us that staff always knocked on the door if they needed a GP while they were with a patient and that all of the staff took great care regarding confidential information. Patients confirmed that they never heard staff discussing patients where others might hear them and that they could not overhear discussions in the GPs rooms. The waiting room and reception area were separate which made it easier to have a private conversation at the reception desk. The staff we spoke with showed a good understanding of the importance of maintaining confidentiality and treating patients with respect.

The managers and staff we spoke with at four local care homes and a residential school that the practice supported were all positive about their relationship with the practice and the service they provided to patients.

Care planning and involvement in decisions about care and treatment

Many of the patients who gave us information said that their GP explained their treatment clearly, listened to them and involved them in making decisions about their health. Some patients indicated that they or a family member had long term health conditions and that they were well supported by the practice to help them manage their health. Patients commented that they felt able to talk to the staff at the practice.

Information leaflets were available in reception and the GPs and nurses printed up to date information from NHS sources to give to patients at their appointments.

Patient/carer support to cope emotionally with care and treatment

The information contained in the comment cards showed that patients felt supported by the practice including when being given concerning news about their health or during difficult times in their lives. Some patients with long term conditions mentioned that the support they had received helped them to cope with their condition. Many patients remarked on the friendly and cheerful manner of the team at the practice.

The GP told us that they provided end of life care for patients in their own homes. When patients died the practice contacted families to check their well-being and offered the opportunity to speak with a member of the team. Information was provided about organisations specialising in providing bereavement support. The practice told us they sent sympathy cards to the family when a patient died.

Information available in the waiting room included details about support and advice which would be helpful for people with long term or life threatening conditions and for carers.

Staff at the care homes and school told us that the GPs and nurses supported patients in a gentle and reassuring way. One of them told us that the phlebotomist and practice nurses were particularly sensitive to patients' anxieties when taking blood and carrying out tasks such as ear syringing.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided general practice cover to people living in three local care homes for older people, one for people with learning disabilities and to a residential school for children and young people with complex physical care needs and learning disabilities. We spoke with the managers or other staff at all of those services. They all described a positive relationship with the practice and told us that the GPs visited routinely every week as well as when specific patients needed to see them.

The practice had a register of people with mental health support and care needs. Each person on the register was invited for an annual review of their overall health. A counsellor funded by the Clinical Commissioning Group (CCG) was at the practice one day a week for two hours. The GPs were able to make direct referrals for patients to them.

The team were alert to the complex needs of people who were living with dementia and had a dementia register. One of the GPs had a long standing interest in the care and treatment of patients living with dementia. The practice recognised the benefits of timely diagnosis, treatment and support for patients and their families to manage their health and the impact of dementia on their lives.

The practice recognised the particular challenges of accessing GP services for people with learning disabilities and had a learning disability register. They provided care and treatment for patients living in a local care home and for children and young people at a nearby residential school. The practice told us they tried to provide these patients with as normal as possible experience of going to their doctor. We learned from staff at the school that the practice was very flexible in making it easier for them to take their students for appointments at the practice. For example, some of the school children needed support from up to four members of staff and could become very distressed and potentially challenging if they had to wait in unfamiliar surroundings. In these situations the practice booked longer appointments and communicated with staff so that they did not bring patients in to the building until the GP was ready to see them.

Tackling inequity and promoting equality

All of the consulting rooms were on the ground floor and there was level access for patients coming into the building. There was a large free car park which provided disabled parking spaces near to the entrance. The toilet had a grab rail to help people with mobility difficulties and there was an alarm call if someone needed to call for help. Baby changing facilities were provided and there was a potty and toddler step for young children.

Staff told us that the practice would be supportive to homeless people who came to the practice to be seen but were not aware of seeing any homeless people in recent times. In a situation where a homeless person did seek medical care from the practice the practice manager explained that they would respond to the person as being in vulnerable circumstances and work with other services to make sure the person was safe. Similarly the practice was not currently providing medical care to any traveller families.

The practice used a telephone interpreting service for any patients who were unable to converse in English. We noted that information leaflets in the practice were only available in English. However, the GPs also had the facility to print up to date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this. The practice website had a facility which patients could use to translate the information provided into a large range of different languages.

The practice had an induction loop to assist people who used hearing aids.

Staff at the care homes and school supported by the practice gave us examples that showed that they worked in a way that did not discriminate against people. For example, staff at the school told us that due to their complex needs some pupils had behaviour that challenged. They explained that the practice staff were aware that this meant that they might not always be able to keep their appointments and were understanding about this.

Access to the service

The practice was situated in a village in a rural location and the team told us they provided a service to people living in an area of 54 square miles with limited public transport. The staff explained that they believed the availability of a dispensing service provided a 'one stop shop' which was invaluable to the widespread rural community they catered

Good

Are services responsive to people's needs?

(for example, to feedback?)

for. The GPs and practice nurses visited patients at home if their health and mobility prevented them from coming to the practice for their appointments. This was the case for acute health problems and for patients with long term conditions whose health needed to be monitored.

The practice was open from 8.30am to 6pm Monday to Friday. Appointments were available from 9am to 12pm and 2pm to 6pm. Many patients informed us that the appointment system at the practice worked well and that they were able to get both routine and emergency appointments when they needed them. Only one patient made a negative comment about this. Several patients commented that when they came to the practice they did not have to wait long before they went in to see the GP or nurse although one patient commented that sometimes had to wait for quite a time.

The practice provided routine appointments for patients up to one year ahead. Patients could telephone for appointments at any time of day and appointments were available to book online. Patients could also book a telephone consultation with a GP without always needing to have an appointment at the practice. The practice sent text message reminders to patients before their appointments.

The practice had in the past introduced extended surgery hours for patients who could not attend during main practice hours but very few patients had used this. The practice had therefore abandoned fixed extended hours but did extend surgery hours to see patients when necessary, for example, if a person needed to be seen the same day and had been fitted in at the end of the afternoon.

The practice provided information about out of hours arrangements on their website and in a leaflet available in the practice.

We saw the results of a December 2013 patient survey for practices within the Redditch and Bromsgrove Clinical Commissioning Group. This showed that the practice scored 90% compared to a CCG average of 74% for patients' ability to get an appointment and were third placed within the CCG. The survey also showed that the practice was rated best within the CCG for getting through to the practice by telephone. The practice score for patients finding this "very easy" was 72% compared to the CCG average of 28%.

Listening and learning from concerns & complaints

The practice had a system for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England but we noted that this did not have a review date recorded. The GP told us that they believed the practice was open about acknowledging any mistakes.

The practice had a low volume of complaints with just two recorded in the previous year. Both of these had been dealt with and resolved. In one case we had a conversation with the complainant who told us that the outcome had been very positive.

Patients told us that they had not needed to make a complaint but felt they would be able to raise a concern if they needed to. We noted that there was information displayed about the complaints process but complaints forms were not readily available to pick up without needing to ask for one at reception.

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

All of the team we met at The Glebeland were polite and respectful about their patients and showed that they wanted to provide patients with a safe and caring service. The practice website told patients that it prided itself on being a friendly practice. The Glebeland had had a presence in Belbroughton since the 1960's. One of the current GPs had joined a relative at the practice in 1991. The relative retired in 1995 and another GP then joined. Both GPs had therefore been at The Glebeland for over 20 years. This gave the practice a strong sense of continuity and community links. In 1994 the practice had moved from a small cottage to purpose built premises and the number of patients had increased from 2,400 to the current 4,400. The practice had recognised that the practice would benefit from having another GP and so were considering looking for a third partner to join them. Their ambition was to build the practice so that it could provide the community with a stable and well run service into the future. The practice was alert to the challenges of GP recruitment but was optimistic that the practice and its location would attract interest.

Governance Arrangements

We found that all members of the team understood their roles and responsibilities. There was a relaxed atmosphere and a sense of teamwork, support and open communication. The practice held annual education days for shared training and learning. The practice held other separate meetings during the year for the practice nurses and for the teams working in the dispensary and reception. The practice manager and the GPs had quarterly meetings. Staff confirmed that they had daily discussions about all aspects of the running of the practice and, where appropriate, the care and treatment of patients.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. The practice informed us that in respect of some aspects of care and treatment they were very active before something became an element for measurement under QOF. This included dementia diagnosis and the care of patients with atrial fibrillation, the most common type of irregular heart rhythm. Diagnosis and treatment is important because it increases the risk of stroke.

Leadership, openness and transparency

Both partners had worked together over a number of years to provide stable leadership. They were supported by a practice manager who had also been in post a long time. Staff told us they felt listened to and said the partners and practice manager supported them well. We found that there had been very little staff turnover and staff enjoyed working at the practice. Staff were supported to learn and develop their skills. The practice nurses had done, or were booked to do, extended training in respect of their lead roles for long term conditions and one had trained as a nurse prescriber.

The practice used a variety of methods to communicate with staff over and above the day to day contact they had with each other. This included a weekly newsletter, email and message and 'task' facilities on the computer system.

Staff described and open culture where they were able to voice their views. The GP told us that they wanted staff to raise any concerns they might have and that they encouraged them to do so openly.

Practice seeks and acts on feedback from users, public and staff

The practice had established a patient participation group (PPG) but this had not been successful and was disbanded after six months. Staff told us that this was partly because patients who took part had not felt that there was much they could say or do to change or improve the practice. The practice could not recall any specific changes they had made as a result of patient feedback. The practice was giving consideration to re-starting the PPG as a 'virtual' group using email and the practice website as the main methods of communication for patients who took part.

There was a box and a supply of comments slips in reception for patients to use if they wanted to give feedback.

There was an established staff team who knew each other well. The team told us they communicated all the time and staff felt they could voice their views.

Are services well-led?

Good

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

Management lead through learning & improvement

We saw evidence that the practice valued the importance of quality, improvement and learning. Two of the three dispensary staff had completed NVQ level three courses in pharmacy services and the practice nurses had completed, or were booked to do extended training relevant to their lead roles for long term conditions. The whole practice team had an annual practice day when they did cardio pulmonary resuscitation (CPR) training and held a full practice meeting. The GP we spoke with told us they also had two or three other training days during the year.

A clinical audit had been carried out in relation to cervical screening. This was linked to one of the nurse's continuous professional development (CPD) and their professional registration. Another audit programme was carried out continuously regarding minor surgery at the practice. This audit focussed on the experience and outcomes for patients and on infection rates in particular. We found that the practice did not have a more comprehensive range of clinical audits to monitor performance and contribute to staff learning.

The practice is a teaching practice which provides placements for medical students who have not yet qualified as doctors. The practice did not have any students on placement at the time we did this inspection.