The Glebeland Surgery

Inspection report

The Glebe
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Date of inspection visit: 27 April 2018
Date of publication: 18/06/2018

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 location	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

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

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at The Glebeland Surgery on 27 April 2018 as part of our inspection programme.

At this inspection we found:

•The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.

•The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

•Staff involved and treated patients with compassion, kindness, dignity and respect. The practice scored higher than average scores in a number of areas of the national GP patient survey 2017.

•Patients found the appointment system easy to use and reported that they were able to access care when they needed it.

•There was a strong focus on continuous learning and improvement at all levels of the organisation.

•There was a strong emphasis on the safety and well-being of all staff.

•Repeat prescriptions were not always produced and signed in accordance with Schedule 6 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and paragraph 39(3) of Schedule 6 to the GMS Regulations.

The areas where the provider must make improvements are:

•Ensure care and treatment is provided in a safe way to patients.

The areas where the provider should make improvements are:

•Review their system for maintaining effective oversight of staff training.

•Review their system to identify and provide support to carers.

Please refer to the requirement notices section at the end of this report for more details.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a member of the CQC medicines team.

Background to The Glebeland Surgery

The Glebeland is situated in a residential area in the Worcestershire village of Belbroughton near Bromsgrove. It has around 4,650 patients. There has been a GP practice called The Glebeland in Belbroughton since the 1960s. The Glebeland is a dispensing practice, which provides dispensing services to patients on their practice list who live more than one mile away from their nearest pharmacy.

The practice is an area with low social and economic deprivation. The practice provides care to patients in two large care homes, a large residential home, a community home for adults with Down syndrome and a large residential school for children with learning and behavioural difficulties. The practice has one male and one female partner and one male and one female salaried GP. The practice has two nurses. The clinical team are supported by a practice manager and a team of three administrative and reception staff. The practice dispensary is staffed by three qualified dispensers.

The practice is a teaching practice which provides placements for medical students who have not yet qualified as doctors.

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. 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.

Requires improvement

Are services safe?

We rated the practice as Requires Improvement for providing safe services. The reason for this is:

•Repeat prescriptions were not always produced and signed in accordance with Schedule 6 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and paragraph 39(3) of Schedule 6 to the GMS Regulations. They were not reviewed and signed by a doctor until after the medicines had been handed out to the patient.

•Blank prescriptions were not being monitored appropriately.

Safety systems and processes

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

•The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. During the inspection we saw examples where the practice had referred patients to social services in order to protect families. Staff knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) Reception staff were not asked to act as chaperones.

•Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.

•The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.

•There was an effective system to manage infection prevention and control.

•The practice had arrangements to ensure that facilities and equipment were safe and in good working order.

•Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

•Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The appointment system was very flexible in order to meet the needs of patients. Patients were able to book routine appointments up to a year in advance.

•There was an effective induction system for all staff tailored to their role. The practice had not used any locum doctors since 2015 as they had now recruited two salaried GPs which provided better continuity for patients.

•The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. All members of staff had received basic life support training. The practice did not have an effective system for maintaining oversight of staff training.

•Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. We saw evidence that sepsis had been discussed at practice meetings.

•When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

•The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.

•The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

•Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

•The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.

Requires improvement

Are services safe?

•The fridge which stored vaccines had been checked by a company in April 2018 and this was done on an annual basis. A thermometer was built into the fridge and was not independent of the power source. The fridge was monitored using a maximum and minimum thermometer and the records showed the fridge had not always stored the vaccines within the correct temperature range. The surgery did not have data loggers to record the temperatures over the weekend. The vaccine expiry dates were regularly checked by the nursing staff. After the inspection we were told that the practice nurse had contacted the relevant manufacturers and confirmed that the vaccine efficacy had not been affected due to the drop in temperature. The practice provided evidence to confirm a data logger had been ordered following the inspection and that a procedure had been put in place to be followed if the weather was expected to be especially cold over a weekend.

•Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.

•The practice had recently reviewed their prescribing of a particular antibiotic to ensure it was in line with current guidelines. An electronic search was carried out for patients on this particular medicine. 17 patients were identified as having been prescribed this medicine. The clinical records of these patients were reviewed to identify the reason for prescribing. 14 patients had been appropriately prescribed this medicine and three patients had been prescribed this medicine inappropriately. The three patients were contacted and placed on alternative medicines.

•Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

•Denaturing kits were available for the disposal of Controlled Drugs. The Clinical Commisioning Group Pharmacist had recently visited as an authorised witness to dispose of the out of date Controlled Drugs.

•The dispensary was in a separate area of the practice and was clearly signed. We noted that the dispensary was secure and not accessible to patients.

•Standard Operating Procedures (SOPs) were available and these covered all processes in the dispensary. They were reviewed annually and we saw evidence that staff had read and understood them.

•Repeat prescriptions could be orded online, in person or on the telephone.

•The dispensary normally dispensed 5000 to 6000 items per month.

•Repeat prescriptions were generated by the dispenser using the computer system. The dispensing labels for those dispensing prescriptions were generated. The medicines were then gathered and the labels attached. Once the labels had been attached the prepared medicines were placed into a basket to await checking. A second dispenser would check the accuracy of the medicines before placing them into a bag.

•On handing out prescriptions the dispensers always checked the patient's address to confirm they were giving the right prescription to the right person.

•During the inspection the dispensers told us that not all dispensed medicines were double checked as sometimes they were working on their own, for example in the early morning and in the evening. The dispensers were in discussion with the GP partners about whether to consider recruiting more staff or installing an IT checking system.

•Repeat prescriptions were not produced and signed in accordance with Schedule 6 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and paragraph 39(3) of Schedule 6 to the GMS Regulations. They were not reviewed and signed by a doctor until after the medicines had been handed out to the patient.The SOP for dispensing items did not specify that the prescriptions should be signed before being dispensed to the patient. The practice had carried out a risk assessment to justify the rationale for not signing prescriptions before they were dispensed to the patient.

•During the inspection the dispenser said that they had tried having the prescriptions signed before being dispensed but this delayed things. The turnaround for repeat prescriptions was 24 hours.

•During the inspection we saw evidence that if a patient made a request for a repeat prescription but had not had their six month review the dispensers would refer the request to a GP for action. The GP would then send a

message back authorising another supply and what type of review was required, if appropriate. The dispenser would attach a slip advising the patient what they must do if they needed any further supplies.

•Weekly blister packes were prepared for nine patients. The request for dispensing into blister packs came from the GPs who identified patients who were having concordance issues with their medicines. The repeat prescriptions were managed by the dispensary staff. Staff were aware of which medicines were not suitable for blister packs.

•Dispensary fridge temperatures were monitored daily. The maximum and minimum temperatures of the fridge were measured and recorded.

•Expiry dates of medicines in the dispensary were checked monthly. Yellow stickers were attached to the boxes when short dated with the expiry date written on to the label.

•The practice participated in the Dispensary Services Quality Scheme.

•The practice carried out Dispensing Reviews of the Use of Medicines (DRUMS). These were carried out by the GPs and nursing staff. The DRUMs target of 438 was achieved (actual figure 476) for 2017/2018. The dispensary staff confirmed they do not carry out DRUMs themselves.

•Both partners were named as responsible for the dispensary.

•Blank prescriptions were kept securely in the dispensary. The serial numbers of the prescriptions were recorded by the dispensary team.

•GPs and nurses had printers in their rooms; these printers did not have a locked printer tray. When GPs left their rooms the rooms were locked. Blank prescriptions were removed from the printers overnight and placed into a locked drawer. The GPs would enter the dispensary and take blank prescriptions. There was no record made of the serial numbers that the GP took to their rooms. We were told that the practice implemented a system to record the serial number of prescriptions that the GP took to their rooms as a result of the inspection.

•Controlled Drugs were stored securely in a Controlled Drugs cabinet. The key to this was kept with one of the dispensers at all times.

•Receipt, dispensing and disposal of the Controlled Drugs were recorded in a Controlled Drugs register and a running balance was kept. Balances and expiry dates were checked on a monthly basis. Out of date and returned Controlled Drugs were kept separate from current stock.

•Dispensary staff knew whom to contact if there were problems with Controlled Drugs or if they had to be disposed.

•Repeat prescriptions for Controlled Drugs were signed before they were dispensed to patients.

•The SOP for the ordering, receipt, dispensing, supply and disposal of controlled drugs was available in the dispensary for staff to refer to if required.

•Staff we spoke with confirmed they knew who to contact if they had an issue with any controlled drugs.

•The dispensary team had quarterly meetings. The meetings were attended by the practice manager and a GP partner.

Track record on safety

The practice had a good track record on safety.

•There were comprehensive risk assessments in relation to safety issues for example health and safety, legionella and fire safety. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

•The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

•Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

•There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. In the last year we saw the practice had recorded 10 significant events. We saw evidence that the practice shared the learning from significant events in the Redditch and Bromsgrove practice forum.

Requires improvement

Are services safe?

•The practice acted on and learned from external safety events as well as patient and medicine safety alerts. We reviewed patients taking a medicine in view of the recent Medicines and Healthcare products Regulatory Agency (MHRA) safety alert which highlighted that this medicine could cause foetal abnormalities and recommended it should not be prescribed to women of child bearing age. The dispenser also said alerts were sometimes printed on the wholesalers' invoices so they would check these as well. The practice had already taken action to identify and contact any patients affected by this. . In some instances we found that the MHRA alerts log was not consistently maintained. Sometimes the practice acted on information shared by the CCG but this was not always documented in the log. The practice were going to ensure moving forward the log was maintained.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

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

•Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.

•We saw no evidence of discrimination when making care and treatment decisions.

•The practice used equipment to improve treatment and support patients' independence. For example, we saw that there was a weighing scale in reception which allowed easy monitoring for patients.

•Staff used appropriate tools to assess the level of pain in patients.

•Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

•Care for older patients was tailored to the individual needs and circumstances, including patient's expectations, values and choices.

•The practice had regular patient care reviews for older patients.

•All older patients had a named GP.

•The clinical staff regularly reviewed unplanned admissions and readmissions.

•The practice offered same day appointments to older patients and same day telephone consultations if this was appropriate for individual patients.

People with long-term conditions:

•The practice had regular patient care reviews, involving patients and their carers.

•The practice supported patients and carers to receive coordinated, multidisciplinary care whilst retaining oversight of their care, acting as a coordinator and navigator of care where appropriate.

•Referrals to specialists were done in a timely manner.

•Proactive monitoring of the prevalence of long term conditions was carried outincluding responding to a sudden deterioration of a conditions, identifying those with a long term condition and those at risk of developing one.

•Clinical staff carried out proactive case management and long-term monitoring of people with long term conditions.

•Same day telephone consultations where appropriate were readily available.

•Patients were signposted to patient groups and supported to access support networks.

Families, children and young people:

•The practice safeguarded children, including early identification of need and early help offered with other services.

•The practice assessed children's development and any early identification of problems in the physical and mental wellbeing of children and young people was followed up as necessary.

•All childhood vaccinations were given within current guidelines and health promotion advice was readily available. For the percentage of children aged one with

completed primary course vaccines the practice was scoring 88%. The practice shared their own unverified data which showed they were now on course to score above 90% in line with the national target.

•The practice shared information and decision making with other agencies, particularly midwives, health visitors and school nurses as appropriate.

•The practice ensured information, including lifestyle advice on healthy living, was given to pre-expectant mothers and expectant mothers and fathers.

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

•The practice had an appointment system which enabled access for this group and they ensured that the practice was easy to contact.

Good

Are services effective?

•Telephone consultations were provided for patients who were unable to attend the practice due to work commitments.

•The practice had access to further services in the practice such as physiotherapy.

•Patients were offered a choice when referred to other services.

•The number of female patients aged 50-70, screened for breast cancer in last 36 months was 83% which was higher than the CCG average of 76% and national average of 70%.

•The number of male patients aged 60-69 screened for bowel cancer in last 30 months was 62% which was higher than the CCG average of 59% and the national average of 55%.

People whose circumstances make them vulnerable:

• People living in vulnerable circumstances were able to register with the practice, including those with no fixed abode

•The practice proactively assessed and monitoredthe practice population needs, including for people in vulnerable circumstances

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

•Patients who were experiencing a mental health crisis were supported to access emergency care and treatment.

•Clinical staff recognised and managed referrals of more complex mental health problems to the appropriate specialist services.

•Care was tailored to patients' individual needs and circumstances, including their physical health needs. This included annual health checks for people with serious mental illnesses.

•The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months was 83% which was in line with the national average of 84%.

•The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 94% which was higher than the national average of 90%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example the practice had carried out an audit to ensure the prescribing of a particular anticoagulant (blood thinning medicine) was in line with current guidelines. 27 patients were identified as being on a repeat prescription of this medicine and 10 patients were found to be on an incorrect dose. The 10 patients on the incorrect dose had their doses changed accordingly. This was re-audited six months later and all patients were found to be on the correct dose.

The practice carried out another audit to ensure all patients on newer blood thinning medicines had been issued with a warning card. The practice carried out an electronic search for patients on these medicines. The practice identified 52 patients and none of these were coded to say that a warning card had been issued. Warning cards were included in the box of these medicines by the manufacturers so patients had them but it had not been coded in the clinical record.

The original search was completed again six months later. 47 patients were identified and all had been coded as having a warning card.

• QOF results were higher than average. In the last year the practice scored 99% which was three percent above the national average.

•The overall exception rate was 7% which was 3% below the national average.

•The practice used information about care and treatment to make improvements.

•The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example the practice reviewed patients suspected of having cancer to ensure they were diagnosed promptly and how effectively the two week wait referral system was being used. They did an electronic search for patients newly diagnosed with cancer. The clinical records of these patients were reviewed to identify how the diagnosis of cancer had been reached, and whether it was as a result of a two week wait referral. 64 patients were identified as being newly diagnosed with

cancer. 63 of these patients had been seen and diagnosed after a referral via the two week wait scheme and one patient had been diagnosed at A&E. this shows good compliance with cancer management guidelines.

•The practice reviewed the assessment and management of a particular type of vertigo using a series of head and neck manoeuvres. The practice identified 12 patients for this treatment. 10 of these patients reported complete cessation of their symptoms and two patients partially responded.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

•Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions. The practice carried out electrocardiograms (ECGs) where appropriate and referred patients if required. An ECG is equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain.

•Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

•The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example one member of the administration team was undertaking deputy practice manager duties at the time of our inspection.

•The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. The nurse had carried out a minor surgery audit and an infection control audit.

•There was a clear approach for supporting and managing staff when their performance was poor or variable.

•Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

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

•We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.

•The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.

•Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

•The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The practice had quarterly palliative care meetings which a member of the district nursing team and Macmillan nursing team also attended.

Helping patients to live healthier lives

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

•The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.

•Staff encouraged and supported patients to be involved in monitoring and managing their own health.

•Staff discussed changes to care or treatment with patients and their carers as necessary.

Good

Are services effective?

•The practice supported national priorities and initiatives to improve the population's health, for example, tackling obesity.

Consent to care and treatment

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

•Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

•Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

•The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

•Feedback from patients was positive about the way staff treat them.

•Staff understood patients' personal, cultural, social and religious needs.

•The practice gave patients timely support and information.

•Survey results were significantly better than national averages in some areas, for example:

•The percentage of respondents to the GP patient survey who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area was 97% compared to the CCG average of 81% and national average of 79%.

•The practice had carried out their own patient satisfaction survey and shared their results during the inspection. Patients were happy with the care they had received over the last 12 months.

•During the inspection we spoke with care home managers who spoke very highly about the GPs at the practice and said they were very caring. They did their weekly ward rounds but were always available to help residents whenever the homes phoned the practice.

Involvement in decisions about care and treatment

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

•Staff communicated with people in a way that they could understand, for example, the practice had a number of easy read documents such as the practice leaflet, a health check letter and health check form.

•Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

•The practice identified carers and supported them. During the inspection the practice identified that 1% of the practice list were registered as carers. They did not keep a separate carers' register but said that they were going to do so after the inspection. The practice signposted carers to different organisations as required and had some leaflets available in the waiting area highlighting organisations such as Carers' Action Worcestershire and carer helplines.

•The survey results were significantly better than CCG and national averages for example:

•The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care was 93% compared to the CCG average of 83% and national average of 82%.

•The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at explaining tests and treatments was 99% compared to the CCG average of 92% and national average of 90%.

Privacy and dignity

The practice respected patients' privacy and dignity.

•Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

•Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

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

•The practice understood the needs of its population and tailored services in response to those needs.

•Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

•The facilities and premises were appropriate for the services delivered.

•The practice made reasonable adjustments when patients found it hard to access services.

•The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.

•Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

•The practice provided dispensary services for people who needed additional support for example by putting their medicines in monthly blister packs.

Older people:

•All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.

•The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice looked after residents in a number of care homes. The care home managers commented on how accessible the GPs were to the residents.

•The GPs and nurses offered services in the community such as asthma and diabetic checks and anticoagulation (blood thinning) monitoring.

People with long-term conditions:

•Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.

•The practice held quarterly meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

•We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.

•All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary. A working mother commented that no matter how minor the problem was with children they had never been made to feel that they were wasting the GP's time.

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

•The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were provided on a Wednesday evening as part of six local practices working together. The practice also offered telephone consultations.

People whose circumstances make them vulnerable:

•The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

•The practice looked after residents at a large residential school for children with learning difficulties. The children from the residential school were bought down to the surgery. The practice offered this to make the transition from school to an adult placement go as smoothly as possible. The practice gave flu and hepatitis B vaccines in the home.

•The practice looked after a large community home for adults with Down syndrome. They carried out learning disability checks and flu immunisations in the community home.

Good

Are services responsive to people's needs?

•People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode

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

•Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Timely access to care and treatment

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

•Patients had timely access to initial assessment, test results, diagnosis and treatment.

•Waiting times, delays and cancellations were minimal and managed appropriately.

•Patients with the most urgent needs had their care and treatment prioritised.

•Patients reported that the appointment system was easy to use. Patients could book appointments a year in advance which was one of the reasons for the low DNA rate.

Survey results were significantly better than average in some areas, for example:

•The percentage of respondents to the GP patient survey who gave a positive answer to getting through to the practice by telephone " was 97% compared with the CCG average of 77% and the national average of 71%.

•The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment was 95% compared with the CCG average of 75% and national average of 73%.

Listening and learning from concerns and complaints

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

•Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.

•The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example we saw two examples where patients were unhappy with their consultation about their weight. Both patients were contacted by the GPs and provided with an apology. They were also given more of an explanation. The practice then discussed this at their staff meeting to share this learning and to ensure that, in future, patients were given a full explanation in sensitive discussions such as this.

•The practice had a comments box in the waiting room with leaflets patients could complete next to it. The practice acted on these appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

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

•Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

•Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

•The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example one of the GP partners was due to retire in July 2018 and they had recruited a new GP partner to start in September 2018.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

•There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners. This was to provide a friendly, accessible and comprehensive service.

•Staff were aware of and understood the vision, values and strategy and their role in achieving them.

•The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.

•The practice monitored progress against delivery of the strategy.

Culture

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

•Staff stated they felt respected, supported and valued. They were proud to work in the practice.There was a low turnover of staff and staff had worked at the practice for several years. The practice manager had been with the practice for 30 years.

•The practice focused on the needs of patients.

•Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

•Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

•Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

•There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. We noted that all staff received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

•Clinical staff felt valued. They were given protected time for professional development and evaluation of their clinical work.

•There was a strong emphasis on the safety and well-being of all staff. For example one member of staff told us how much support they had received on returning to work following a period of absence. Another member of staff who had not previously worked in healthcare described how supportive the GP partners had been. They had developed a glossary with terminology to help the member of staff carry out administrative duties.

•The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.

•One member of staff informed us during the inspection that they had suggested the administrative staff have a different more practical uniform. This was immediately implemented by the practice manager and GPs.

•There were positive relationships between staff and teams.

Governance arrangements

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

•Structures, processes and systems to support good governance and management were clearly set out,

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understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

•Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control

•Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

•There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.

•The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.

•Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality in a number of areas.

•The practice had plans in place and had trained staff for major incidents.

•The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

•Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

•Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

•The practice used performance information which was reported and monitored and management and staff were held to account.

•The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

•The practice used information technology systems to monitor and improve the quality of care.

•The practice submitted data or notifications to external organisations as required.

•There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

•A full and diverse range of patients', staff and external partners' views and concerns was encouraged, heard and acted on to shape services and culture. There was a virtual patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Before the inspection we contacted two members of the virtual PPG who informed us that the practice manager updated them regularly and was very approachable. They felt that the virtual PPG worked well.

•The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

•There was a focus on continuous learning and improvement.

•The practice was very flexible and accessible which in turn led to high levels of patient satisfaction.

•The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

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•Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **How the regulation was not being met?** **There was no proper and safe management of medicines. In particular:Prescriptions were not produced and signed in** **accordance with the relevant regulations.This was in breach of regulation 12 of the Health and Social Care Act** **2008 (Regulated Activities) Regulations 2014.**