Brewood Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brewood Surgery, the main branch on 12 March 2015. The other two branches were not inspected as part of this visit. Overall Brewood Surgery is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances make them vulnerable. It was outstanding in areas for people experiencing poor mental health (including people with dementia).

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However although information about safety was reported monitored and reviewed, records to demonstrate how they were addressed were not consistently recorded.
- Risks to patients were assessed and well managed with the exception of areas related to infection control and checking of equipment.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. However verbal complaints were not recorded and monitored.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice had developed and implemented a dementia care management plan. Patients had a dedicated one hour consultation with a GP and had their clinical assessments and screening carried out by the same group of staff which ensured continuity in the staff that they saw.

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

Action the provider SHOULD take to improve:

- Maintain consistent records to clearly demonstrate the discussions and actions taken to address and review safety incidents.
- Review toilet facilities to ensure that they are clean and that paper towels and suitable bins are provided.
- Review the systems in place for checking emergency equipment.
- Implement systems to record and monitor verbal complaints.

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. There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable patients who used the service. There was regular monitoring of safety to ensure that ways to improve were identified and implemented. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. However, the practice was not consistent in recording the analysis and outcome of investigations of all safety incidents. Lessons were learned and communicated widely to support improvement. A fridge located in a treatment room was in use although not checked to ensure that it was safe for use since 2008. Paper towels and suitable bins were not provided in all toilet facilities. Systems for checking emergency equipment were not robust. Patients who used the service told us that they felt safe. There were enough staff to keep people safe.

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to

Summary of findings

secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Records were not maintained of verbal complaints received.

The practice had developed and implemented a dementia care management plan. Patients had a dedicated one hour consultation with a GP and had their clinical assessments and screening carried out by the same group of staff which ensured continuity in the staff that they saw.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and regular home visits were available when needed. All these patients had a named GP, named lead nurse and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GP and nurse worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients with long-term conditions who found it difficult to get to the practice had care delivered in the community where appropriate.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good 

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good 

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability. The practice did not have a register of patients living in vulnerable circumstances such as homeless people or travellers, but would offer a service to patients if needed.

People experiencing poor mental health (including people with dementia)

Outstanding 

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). Information available showed that 90.6% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. There was a psychologist attached to the practice who provided support for patients who experienced poor mental health. It carried out advance care planning for patients with dementia. The practice had developed and implemented a dementia care management plan. Patients were entered into a two stage dementia assessment process and clinical assessments and screening were carried out by the same group of staff which ensured continuity in the staff that patients saw. Patients had a one hour clinical appointment with the lead GP for dementia care. The results of the project showed that the number of patients diagnosed with dementia had increased from 42 patients in September 2014 to 77 patients at the time of inspection. Improved outcomes noted for newly diagnosed patients included timely access to memory clinics and an increase in the appropriateness of referrals.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection, one of whom was a member of the practice patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. We spoke with and received comments from patients who had been with the practice for a number of years and patients who had recently joined the practice. Patients we spoke with during the inspection were extremely positive about the service they received. They told us that they were treated with respect, extremely satisfied with their care and treated with compassion. Patient's described the staff and GPs as always helpful, excellent and told us that staff were always listened and asked them for updates on their health and well-being.

We reviewed 34 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of comments made were positive about the service they experienced. Patients said that staff talked to them correctly, dealt with them promptly and professionally, always listened and helped and offered an excellent service. They said staff were very good, caring, respectful and polite.

The January – March 2014 and July – September 2014 national GP patient survey showed that practice performed well in all areas. These included:

- 83% of respondents described their experience of making an appointment as good as compared with the local CCG average of 77%
- 90% of respondents said that the last nurse they saw or spoke to was good at involving them in decisions about their care as compared with the local CCG average of 84%
- 93% of respondents said they found the receptionists helpful as compared with the local CCG average of 88%
- 96% of respondents said that they had confidence and trust in the last GP they saw or spoke to as compared with the local CCG average of 97%
- 92% of respondents said that the last GP they saw or spoke to was good at listening to them as compared with the local CCG average of 91%
- 98% of respondents said that they had confidence and trust in the last nurse they saw or spoke to as compared with the local CCG average of 97%
- 89% of respondents said that they would recommend the practice to others as compared with the local CCG average of 61%

Areas for improvement

Action the service SHOULD take to improve

- Maintain consistent records to clearly demonstrate the discussions and actions taken to address and review safety incidents.
- Review toilet facilities to ensure that they are clean and that paper towels and suitable bins are provided.
- Review the systems in place for checking emergency equipment.
- Implement systems to record and monitor verbal complaints.

Outstanding practice

- The practice had developed and implemented a dementia care management plan. Patients had a

Summary of findings

dedicated one hour consultation with a GP and had their clinical assessments and screening carried out by the same group of staff which ensured continuity in the staff that they saw.

Brewood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included two specialist advisors a GP and a practice manager, and an Expert by Experience. An Expert by Experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to Brewood Surgery

Brewood Group Medical Practice comprises three branches, Brewood Surgery, Wheaton Aston and Coven. We carried out an announced comprehensive inspection at Brewood Surgery, the main practice site, the other two branches were not inspected as part of this visit. This semi-rural practice is based in Brewood but also serves the villages of Coven, Coven Heath, Wheaton Aston, Stretton, Lapley and Bishopswood, as well as outlying hamlets. The Brewood Group Medical Practice provides dispensary services at one of its branches. The practice has a patient list size of 10,300 over all three sites. The practice is situated within an area of less deprivation when compared to other areas in the local Clinical Commissioning Group (CCG) area of NHS Stafford and Surrounds. Its main population age group as shown in 2014 are patients aged between 45 and 85 plus with a significant number of these aged between 65 and 69.

The practice is a single storey purpose built building constructed in 1960. The building is in a very poor condition and there is limited car parking. The practice is in the process of undertaking a new practice building programme which is being funded by the GP partners. The completion date for this new build is September 2015. The plans for the new building are displayed in the main waiting area. The opening times at the practice are between 8am and 6pm Monday to Friday. Patients can book appointments in person, on-line or by telephone. Extended hours are available on Tuesday and Thursday morning between the hours of 7am and 8am and Monday, Tuesday and Friday evenings between the hours of 6.30pm and 7.30pm.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. Services provided at Brewood Surgery include the following clinics; family planning, new patient medicals, asthma, diabetic, baby vaccination and wellbeing screening clinics.

The team of clinical staff at Brewood Group Medical Practice consists of six practice nurses (female), two health care assistants, 4.5 WTE GP partners and 1.5 WTE salaried GPs (four male and three female), phlebotomist (a person that takes blood for tests), A practice manager, reception manager, reception, administrative and secretarial staff provide management and administration support for the practice.

Brewood Group Medical Practice is an approved GP training practice for Registrars (qualified doctors who undertake additional specialist training to gain experience and higher qualification in General Practice and family medicine). Other allied professionals and students may, on occasion, be sitting in with the doctor or nurse. The practice is also an accredited teaching and training practice for medical students and newly qualified doctors.

Primecare provides an out of hours service for patients when the practice is closed and information is provided to patients about the NHS 111 service.

Detailed findings

Why we carried out this inspection

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We asked NHS England, Stafford and Surrounds CCG and the local Healthwatch to tell us what they knew about Brewood Surgery and the services they provided. We reviewed information we received from the practice prior to the inspection. The information we received did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 12 March 2015. During our visit we spoke with a range of staff including GPs, practice manager, practice nurses, healthcare assistants and reception and administration staff. We spoke with ten patients and members of the patient participation group (PPG) who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed surveys and comment cards where patients shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. National patient safety alerts were disseminated by the practice manager to practice staff.

The practice had a system in place for reporting, recording and monitoring safety incidents. These were collated by the practice as significant events. Staff used significant event forms and sent completed forms to the practice manager. There were records of significant events that had occurred during the last year and we were able to review these. For example, we saw that an incident had occurred whereby specimens were mislabelled resulting in a delay in treatment. We saw that appropriate action had been taken and the issue raised as a significant event. Following analysis of the significant event we saw that the importance of correct labelling of specimens were discussed with all staff, procedures for checking the labelling of specimens had been reviewed and updated. Records we examined detailed 16 safety incidents that had occurred between March and September 2014.

We reviewed safety records, incident reports and minutes of monthly significant event meetings where these were discussed. Minutes of meetings showed that safety incidents had been reviewed. Information available however did not consistently demonstrate how incidents were managed over time. For example the minutes of a clinical meeting held on 3 July 2014 indicated that two significant events were discussed at length with the whole practice team and referred the reader to the significant event forms for the outcomes. The forms described the incident but there were no details to demonstrate the outcomes and action implemented to prevent reoccurrence of the incidents. Minutes of meetings we looked at did not provide information to show that actions from past significant events were reviewed.

Learning and improvement from safety incidents

We saw that incidents, complaints and other significant events were discussed at the practice meetings There was evidence that the findings were shared with relevant staff. The minutes of the meetings showed that they were attended by both clinical and non-clinical staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The practice indicated in the minutes the process they followed when reviewing significant events these included discussing the event, agreeing the outcomes and sharing the learning. We found that there was a lack of information to clearly demonstrate learning and improvements made. We did find however that complaints received by the practice were thoroughly investigated. We saw the report contained brief details of the complaint, the outcome, action to be taken to prevent reoccurrence and details of the learning shared with all staff. Staff we spoke with confirmed this.

We tracked six significant events and saw records were completed in a timely manner. The minutes of meetings indicated that incidents were discussed at length. Staff we spoke with told us that a review of practice had been implemented for example following incidents where specimens had been incorrectly labelled and where wound sutures had not been removed correctly. We noted that an incident discussed and recorded in the minutes of a team meeting had not been reviewed as a significant event. This related to an error with a prescription, which was dealt with by one of the GPs and changes made to prevent reoccurrence. The practice manager told us that consideration would be given to issues discussed at team meetings to determine whether they should be processed as a significant event. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at monthly staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. We saw that following an alert regarding the use of a medicine used to lower blood cholesterol and a medicine to reduce high blood pressure that patients were called in for a review of their medication to ensure they received the correct dosage of these medicines.

We saw that significant events were followed up and referred or shared with other professional agencies outside

the practice where appropriate. The local Clinical Commissioning Group (CCG) who monitored the performance of the practice told us that they did not have any concerns about this practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and displayed throughout the practice.

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. Prior to our inspection, we spoke with a health visitor who worked with the practice. They told us that the GPs worked closely with the health visiting service to support children and their families. The health visitor told us that there was also a system in place that ensured that the health visiting service were made aware of new children who registered with the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. This included identifying and reviewing vulnerable adults for example patients who experienced poor mental health and children with a high number of A&E attendances.

There was a chaperone policy, which staff could access through the practice intranet. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Signs informing patients of their right to have a chaperone present during an intimate examination were displayed throughout the practice. Nursing staff we spoke with told us they had received chaperone training during their nurse training. They clearly explained to us what their responsibilities were to keep patients safe from the risk of abuse. Reception staff told us they had acted as a chaperone if nursing staff were not available. All staff had received formal chaperone training to help them to understand their responsibilities when acting as chaperones. The receptionists we spoke with recognised the need to be able to clearly observe the examination and were aware of what action to take if they had any concerns.

Medicines management

We checked the medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. However records on one of the fridges showed that it had not been calibrated and checked since September 2008. The practice told us that this was not the case however could not provide the evidence to confirm this. We were told that vaccines and medicines were not stored in this fridge; however the fridge had not been put out of action so that staff were aware that it should not be used. In the long term the practice had plans in place to replace this fridge. We noted that the actual temperatures of the fridges that stored medicines were recorded; however the temperature ranges (minimum and maximum temperatures) were not recorded. Recording these temperatures would demonstrate that medicines and vaccines were stored within the recommended temperature at all times.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice held a small stock of controlled medicines; these were stored securely and were only accessible to authorised staff. We saw that these were regularly checked and any out of date controlled medicines were destroyed appropriately by the pharmacist.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be

individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines. Two of the practice nurses were nurse prescribers. They had completed a specialist course and attended a medicine management workshop annually.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were appropriate and necessary. There were systems in place to check that GP prescription pads used could be tracked through the practice.

Cleanliness and infection control

We observed that generally most of the premises was visibly clean and tidy. We saw that the toilets were not clean and toilet paper was not available. We saw that there was a cleaning schedule in place. However, the schedule in one of the toilets had not been completed to show that the toilets had been cleaned daily in line with the cleaning schedule. We spoke to the practice manager about this and were reassured that this would be reviewed with the external cleaning company they used. Patients we spoke with told us they found that the toilet facilities were not always clean. Comments from patients also confirmed that paper towels were not always available and on one occasion a cloth towel was provided which they did not consider to be hygienic.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received training about infection control specific to their role. Although infection control audits had been carried out we saw practises that showed that infection control practices were not always followed. For example bins provided in toilets were not foot operated and required patients to use their hands to open them.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they used these in order to comply with the practice's infection control policy. We saw that hand washing gel had been made readily available throughout the practice. There was a policy for needle stick injuries and staff knew what to do if this occurred. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had processes to protect staff and patients from the risks of health care associated infections. We saw records that demonstrated that clinical staff had received the relevant immunisations and support to manage the risks of health care associated infections. We saw that a legionella risk assessment had been completed in December 2014 to protect patients and staff from harm. We saw that appropriate action had been taken to address any risks identified. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that there were procedures in place to prevent the growth of legionella. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw records that demonstrated all portable electrical equipment had been tested in May 2014 to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in March 2015 to ensure the information they provided was accurate. This included devices such as weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment and in line with the practice's policy. This included proof of identification, references, qualifications and registration with the appropriate professional body.

We saw that Disclosure and Barring Service checks (DBS) had been carried out for all clinical and non-clinical staff working at the practice. DBS checks are carried out to

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.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We saw that staffing rotas were planned in advance to ensure adequate staffing levels were maintained.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated that weekly, monthly and annual checks of the building had been carried out. This included a fire risk assessment and fire drills for staff; gas safety checks; emergency lighting tests and fire alarm testing. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed.

We saw that where risks were identified that action plans had been put in place to address these issues. The practice manager showed us the practice's risk management report and an agenda for an action log meeting to discuss the risks identified in the report. We saw that a building maintenance policy was in place. Schedules were identified for maintenance. The practice had a risk assessment policy this identified risks related to the practice. The practice had completed a risk assessment table where specific risks related to the practice were documented. We saw that each risk was rated and mitigating actions recorded to reduce and manage the risk. We saw that appropriate action had been taken to address any risks identified.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff we spoke with told us that children were always provided with an on the day appointment if required although this may be through the sit and wait clinic held at the practice. The health visitor we spoke with also confirmed this. One of the GPs told us that the local Clinical Commissioning Group (CCG) informed them of their most vulnerable patients so they could provide additional support if needed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all clinical staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. We found however that some of the equipment on the trolley was out of date although a tick list system had been completed monthly indicating that the equipment had been checked and considered fit for purpose.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and the loss of domestic services. The practice had a fire risk assessment carried out in October 2014. The report included actions required to maintain fire safety and the practice had addressed these. Records showed that staff were up to date with fire training, a practice fire drill had been carried out in December 2014 and that all fire extinguishers were checked annually.

Staff were aware of the process to follow in the event of an emergency or deterioration of a patient's condition while attending an appointment at the practice. Reception staff told us that they would refer a patient to a GP immediately if they had a concern about a their wellbeing.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). For example, clinical staff described how they had used the NICE guidelines for the management of high blood pressure in patients, diabetes and asthma. We saw that the GPs and nurses used clinical templates in the management of patient care and treatment. This assisted them to assess the needs of patients with long term conditions, older patients and patients experiencing poor mental health. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as minor surgery and obstetrics and gynaecology, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. We saw training certificates which demonstrated that practice nurses had received the additional training they required for the review of patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines.

All the GPs we spoke with used national standards for the referral of patients with suspected cancers so that they were referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us one clinical audit that had been undertaken in the last 12 months. This was a completed audit cycle where the practice was able to demonstrate the changes resulting since the initial audit. The audit looked at whether patients diagnosed with atrial fibrillation (AF), a heart condition that causes an irregular and often abnormally fast heart rate were assessed for the risk of a stroke. Research showed that patients with a high score are at significant risk of a stroke. The assessment is used to determine whether or not the patient needed to be treated with anticoagulation therapy to decrease the risk of a stroke. Anticoagulation therapy is a medicine used to prevent the formation of blood clots in patients. After two cycles of this audit the practice were able to demonstrate that the number of patients with AF who had been tested had risen from 57% in August 2014 to 90% in November 2014.

The GPs told us that audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, QOF data demonstrated that the practice was below the national average for providing patients with the seasonal flu vaccine. Staff at the practice were able to demonstrate that following this review that the number of patients who received the vaccine had increased. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example 87.6% of patients with asthma, 87.2% of patients with rheumatoid arthritis and 90.6% experiencing poor mental health had received an annual review. These results were above the national target. The practice told us that

Good

Are services effective?

(for example, treatment is effective)

there were nine patients with a learning disability registered with the practice and all these patients had an agreed care plan in place. The practice was less proactive in implementing care plans for patients with chronic obstructive pulmonary disease only 69.2% of these patients had an agreed care plan in place compared with the national average of 90%. (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema). The practice had systems in place to review and address this.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. We saw that multi-disciplinary working between the practice, district and palliative care nurses took place to support these patients. We saw there was a system in place that identified patients at the end of their life. This included a palliative care register of five patients and alerts within the clinical computer system making clinical staff aware of their additional needs.

The practice participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data highlighted areas where the practice was performing well and areas they needed to improve. For example, a brief report we looked at showed that the practice participated in a peer review of the appropriateness of outpatient referrals with another practice in their locality.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that clinical and non-clinical staff were up to date with attending mandatory courses such as basic life support. We noted a good skill mix among the GPs, practice nurses and healthcare assistants. GPs held qualifications in sexual and reproductive health, children's health and mental health. All the GPs we spoke with were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, GP registrars who were training to be qualified as GPs had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

The practice had invested in building a team of practice nurses that provided the capacity to take the time needed to meet the needs of patients with long-term conditions. The practices nurses' role included developing a service that provided patients registered with the practice with ongoing care and treatment in their homes where appropriate. Practice nurses were expected to perform defined duties and had extended roles. The practice nurses were able to demonstrate that they were trained to fulfil these duties. For example, practice nurses had additional qualifications in asthma, diabetes, prescribing, administration of childhood immunisations and cervical screening. Health care assistants had received training to take blood specimens and undertake health screening of new patients.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they

were received. The GP who saw these documents and results was responsible for the action required. All the staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a shared care record.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence that the practice had used significant events to learn and improve information sharing between the practice and other providers.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record information system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw there was a MCA 2005 policy in place to support staff in making decisions when capacity was an issue for a patient. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us that approximately 73% of these care plans had been reviewed in the last year. When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, there was a formal consent form for patients to sign which demonstrated they were aware of the relevant risks, benefits and complications of the procedure. Consent forms were scanned into patients' notes. We saw an anonymised record where this had been completed.

Health promotion and prevention

Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw data that demonstrated the practice was in line with the regional Clinical Commissioning Group (CCG) average in the uptake of childhood immunisations.

There were systems in place to support the early identification of cancers. The practice carried out cervical screening for women between the ages of 25 and 64 years. We saw that the practice's performance for cervical screening was 77.6% which was in line with the national average. The practice was also proactive in screening for cancers such as bowel and breast cancer.

The practice nurses actively engaged their patients in lifestyle programmes. The practice had performed better than other practices in the local CCG area for monitoring and supporting patients who smoked. Information showed that 87.7% of patients had their smoking status recorded and had accepted support to help them stop smoking. Practice nurses described to us how they sign posted patients to weight loss clinics and completed exercise referrals for patients who needed to manage their weight.

We saw that up to date health promotion information was displayed, available and easily accessible to patients' in the waiting area of the practice. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above

Good

Are services effective?

(for example, treatment is effective)

average for the local Clinical Commissioning Group (CCG), and again there was a clear policy for following up non-attenders by the named practice nurse. However the percentage of older people who had received a seasonal flu vaccination was lower than the local average.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of nine patients with a learning disability. Annual health reviews were routinely carried out for these patients. The practice worked with the local CCG learning disability nurse to support these patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The Quality Outcome Framework (QOF) data showed that the practice was below national standards in providing flu immunisations for patients over the age of 65. We saw that the practice had reviewed this and put an action plan in place to address this issue.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 128 replies to the national patient survey carried out during January-March 2014 and July-September 2014. The evidence showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the results from the national patient survey showed that 90% of respondents said that their overall experience of the practice was good or very good and 85% of respondents said they would recommend the practice to someone new to the area. These results were generally in line with the CCG regional average. The practice was above the CCG regional average for its satisfaction scores on consultations with GPs. For example, 92% of respondents said the GP was good at listening to them and 90% said the GP gave them enough time as compared with the local CCG average of 89% and 87% respectively. This level of satisfaction was also reflected in the patients responses on their consultations with the practice nurses. For example, 94% of respondents said the nurse was good at listening to them and 96% of respondents said the nurse gave them enough time as compared with the CCG regional average was 83% and 85% respectively.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 34 completed cards and all were positive about the service experienced. Patients said the staff were caring, kind, friendly and treated them with dignity and respect. They said the nurses and doctors listened and discussed their needs with them and they were involved in decisions about their care. We also spoke with ten patients on the day of our inspection. Patients told us that receptionists were helpful and thoughtful.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk and the seating area within the waiting room made it easier for confidential conversations to take place. Reception staff that we spoke with also explained that patients were invited to continue confidential conversations whether in person or on the telephone calls in a private room.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception areas stating the practice's zero tolerance for abusive behaviour. Receptionists could refer to this to help them to manage potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas. For example, data from the national patient survey showed that 87% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were in line with the CCG regional average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice was proactive in identifying and communicating concerns about older patients registered with the practice. They told us that the practice nurses worked actively within the community to support and

Good

Are services caring?

involve older patients and their carer where appropriate in decisions about their care. Structured multi-disciplinary meetings were held at the practice on a four weekly basis to discuss the care of patients with end of life care needs. We saw minutes from meetings that confirmed this.

We spoke with representatives two care homes for older people. They told us that all the patients living there who were registered with Brewood Surgery had a named GP and received regular medication reviews. They also told us that when a do not attempt cardio-pulmonary resuscitation decision had been made regarding a patient, that the patient and their family were fully involved in those decisions. They told us the GPs reviewed these decisions at regular intervals with the patient and important others. People are able to make the decision that they do not wish receive cardio-pulmonary resuscitation in the event of severe illness. These decisions must be recorded and authorised by a medical professional. There are clear guidelines and timescales to abide by and the decision must be reviewed to ensure it still stands.

Staff told us that translation services were available for patients who did not have English as a first language. This enabled them to be involved in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 92% of respondents to the national patient survey said the last GP they saw or spoke with was good at treating them with care and concern and with a score of 95% for the nurses. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

The lead GP told us that if families had suffered a bereavement, their usual GP contacted them. Patients told us that they had received visits at their homes from GPs and nurses. If necessary, they were also signposted to bereavement support and counselling provided by the local hospice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, 27% the practice population were patients in the older population age group. The practice provided services to ensure their needs could be met. For example, practice nurses were involved in delivering care in the community to housebound patients, patients with complex health needs and patients who found it difficult to get to the practice.

The practice had identified that they had low diagnosis rates for patients with dementia and that there had not been a significant reduction in the number of patients waiting to attend a memory clinic. To address this the practice undertook a project called 'Brewood Dementia Plan' to identify patients registered at the practice who had an increased risk of dementia and to diagnose their condition. A clinical search of patients at increased risk of dementia was carried out and all patients with suspected dementia were referred to the lead GP for dementia care.

The practice developed and implemented a dementia care management plan. This was a two stage dementia assessment process. Patients identified with signs of dementia were entered into the second stage of the dementia assessment process. These patients had their clinical assessments and screening carried out by an identified group of staff which ensured continuity in the staff that patients saw. For example a designated health care assistant (HCA) was assigned to the project. The HCA carried out blood tests and an electrocardiogram on referred patients. Patients then had a one hour clinical appointment with the lead GP for dementia care. The results of the project showed that the number of patients diagnosed with dementia had increased from 42 patients in September 2014 to 77 patients at the time of inspection. Improved outcomes noted for newly diagnosed patients included timely access to memory clinics and an increase in the appropriateness of referrals.

We saw that there was a psychologist attached to this practice who provided support for patients who experienced poor mental health.

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with a spokesperson from the PPG who told us that following their patient survey in 2014. The results of the survey showed that patients were happy with the service they received. We saw that where concerns had been raised action were taken to address them. For example, some patients expressed the need for additional extended opening times. The practice had put an action plan in place to address this with the PPG in order to determine how they could meet patients needs.

Tackling inequity and promoting equality

The practice provided equality and diversity training for all staff and we saw evidence of this. Staff we spoke with confirmed that they had completed equality and diversity training. We looked at the training matrix in place at the practice and saw that it identified when the training would need to be updated.

The practice recognised the needs of different groups in the planning of its services. The practice was a one storey building. We saw that the waiting area was small and not easily accessible to patients with wheelchairs and prams. The patients were not concerned about this and told us that they could access the treatment and consultation rooms easily. Patients told us that they were provided with access to a room where they could talk privately if they wished. We saw that the plans for the new build practice had considered ease of accessibility for patients.

Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included step free access to the entrance of the practice and an intercom system at the front entrance enabled patients to ring for help to enter the building.

For patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided care and support to several house bound elderly patients. Patients over 75 years of age had a named GP to ensure continuity of care. The practice held a register of nine patients with a learning disability registered with the practice and all of these patients had an agreed care plan in place to support their needs.

Access to the service

Comprehensive information was available to patients about appointments on the practice's website and in the practice leaflet. This included how to arrange routine and urgent appointments and home visits and how to cancel appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Patients could book appointments in person, on-line or by telephone.

We looked at the national patient survey results published in January 2015 and saw that 83% of respondents described their overall experience of making an appointment as good or very good. Patients we spoke with and comments made in comment cards also confirmed that patients found that appointments were easily accessible.

The normal opening hours for the practice was 8am to 6pm, Monday to Friday. The practice also offered extended hours outside of the practice normal working hours for patients unable to attend due to work commitments or rely on other people bringing them to the practice who go to work. Extended clinic hours offered were available on Tuesday and Thursday morning between the hours of 7am and 8am and Monday, Tuesday and Friday evenings between the hours of 6.30pm and 7.30pm.

The practice offered pre-bookable appointments which patients could make up to 28 days in advance. For those patients who wish to be seen on the same day systems were in place for the designated duty GP to contact the patient by telephone to assess the person's clinical needs and make a decision as to whether an appointment was needed. The patient would then be booked an appointment to see the duty GP.

Longer appointments were available for patients who needed them this included those with long-term conditions. Staff told us that children and older patients were always seen on the same day that they requested an appointment.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that there was information on the practice website and a poster in the waiting room informing patients how to complain. However we saw that verbal complaints were not recorded to identify trends and confirm that they were resolved.

We looked at four complaints received for the period 1 April 2014 and 27 February 2015. We found that all but one complaint had been responded to and dealt with in a timely manner and that there was openness and transparency when dealing with them. The practice reviewed these complaints to detect themes or trends. We looked at their complaints review report for the previous 12 months. We saw that lessons learned from individual complaints had been acted on. The practice manager told us that the delay in responding to one of the complaints was due to them being on leave. The practice did not have a process in place for following up a complaint in the absence of the practice manager. The practice manager assured us that these issues would be addressed.

Information contained in the complaint report showed that a thorough investigation had been carried out and that the issues were discussed with staff involved. The report contained brief details of the complaint, the outcome, action to be taken to prevent reoccurrence, which included a review of clinical practice and policies and procedures where required. The report also detailed the learning shared with all staff. We saw practice meeting minutes that demonstrated complaints were a regular agenda item. This supported staff to learn and contribute to any improvement action that might have been required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide the best possible quality service for patients within a confidential and safe environment. The practice values included to show patients courtesy and respect at all times irrespective of ethnic origin, religious belief, personal attributes or the nature of the health problem; to involve patients in decisions regarding their treatment; to promote good health and wellbeing to patients through education and information and to involve allied healthcare professionals in the care of patients where it is in their best interests.

In keeping with their vision we saw that patients were treated with respect and compassion and patients we spoke with told us that staff were polite and respectful towards them. Information we read showed that patients were involved in their care. Patients told us that self-care was promoted and this helped them to understand and manage their illness. Information available showed that patients were referred to other professionals for tests and treatment in a timely way. Patients we spoke with and comments in comments cards we received confirmed this.

We spoke with ten members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The practice did not have a written strategy or business plan in place. However the practice told us that their main focus for their development was the new build practice and ensuring that the move to the new premises went smoothly for patients and practice staff. The practice would then look at developing a business plan which allowed the practice to focus on future planning in taking the practice forward. We saw that the contents of the minutes of the monthly business meetings attended by all partners and the practice manager showed discussions about forward strategy and planning.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's intranet. We looked at 10 of these policies and procedures. We saw that these were dated to reflect the date they were reviewed.

There was a clear leadership structure with named members of staff in lead roles. For example, there were lead nurses for infection control and the management of long-term conditions. We saw that GPs had lead roles for safeguarding, paediatrics (care of children), dementia care and minor operations. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed it was performing in line with national standards with a practice value of 90% compared with a national value of 93.5%. We saw that QOF data was regularly discussed at monthly governance meetings. We saw that actions had been taken to maintain or improve patient outcomes. This included putting plans in place to increase the number of patients aged 65 and older provided with the seasonal flu vaccination.

Although limited there was evidence of clinical reviews. We saw one completed to full audit cycle. This is where a second audit is undertaken to demonstrate whether improvements to services have been achieved. We saw that reviews of patients care was completed to improve performance and patient outcomes. For example, an audit of patients diagnosed with atrial fibrillation (AF) a heart condition that causes an irregular and often abnormally fast heart rate were assessed for the risk of a stroke. After two cycles showed an increase in the number of patients with AF who had been tested had risen from 57% in August 2014 to 90% in November 2014.

The practice had arrangements for identifying, recording and managing risks. The practice manager had developed a risk log which identified the level of impact each risk posed to the practice, a risk lead, a plan of action and a review date. The practice had completed a risk assessment table where specific risks related to the practice were documented. We saw that each risk was rated and mitigating actions recorded to reduce and manage the risk. We saw that appropriate action had been taken to address

Are services well-led?

Good

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

any risks identified. The risk table identified risks to patients, particularly children and clinicians due to sharp boxes placed on the floor in clinical rooms. This practise was reviewed and measures put in place to address it.

Governance arrangements for the management of controlled drugs (CDs) held at the practice were in place. CDs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found that the number of CDs held at the practice were in line with what was recorded in the CD log book.

Leadership, openness and transparency

All the staff we spoke with told us that the staff working at the practice were a close team. Staff said that the management team and GPs were approachable. Practice meetings were held monthly and staff received monthly one to one supervision and annual appraisals. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at practice meetings. The practice had a whistle blowing policy which was available to all staff to access by the practice intranet. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected. We saw an example of where the procedure was implemented and was effective.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and disciplinary procedures which were in place to support staff. We were shown the staff handbook that was available to all staff which included sections on equality, whistleblowing and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, suggestion boxes, friends and family test, comment cards and complaints received. Patients had access to the friends and family test on the practice website. Patients were given access to the test via a laptop in the patients waiting area. This method had been successful; figures showed that between September 2014 and March 2015 the practice had received 648 hits from patients. The results for this period showed that 92% of respondents were extremely likely or likely to recommend the practice to friends or family if they needed similar care or treatment. An action plan was also formulated to address comments made by patients. These included looking at increasing early morning and evening appointments and replacing the 0844 telephone number with a local number. We also looked at the results of the patient participation group (PPG) patient survey for 2013 – 2014 and saw appropriate action was taken to address comments and suggestions made by patients. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The practice had an active PPG which consisted of 10 members. The PPG included male and female members with an age range of 32 years and above. The PPG is represented by patients from all three branches of the practice. The PPG met quarterly with staff members and GP partners from the practice. The practice manager showed us the analysis of the last patient survey, which was discussed with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had monthly protected learning time.

The practice was a training practice for GP registrars to gain experience and higher qualifications in General Practice and family medicine. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. The practice is also an accredited teaching and training practice for medical students and newly qualified doctors who are in year two of 'The Foundation Programme' (FY2). The Foundation Programme is a

Are services well-led?

Good

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

two-year training programme for doctors after leaving medical school. It is designed to give trainees a range of general experience and enable them to take on supervised responsibility for patient care as a professional in the workplace, before choosing an area of medicine in which to specialise. We saw that there was also a supervision system for nurses and this role was fulfilled by one of the GPs.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We saw minutes that confirmed this.