Stanmore House Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 3 December 2014 as part of our new comprehensive inspection programme.

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

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

We saw several areas of outstanding practice including:

- The practice provided an Xpert Diabetes Programme (XDP). The aim of this programme was to provide patients with the knowledge, skills and confidence necessary to self-manage their diabetes. The practice was able to demonstrate a sustained reduction in blood sugar levels among patients who had attended this programme.
- Data reviewed showed that Wyre Forest Clinical Commissioning Group (CCG) had the highest rate of excess weight in four to five year olds out of the six Worcestershire districts. This summer the practice was involved in a community engagement exercise at a

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local primary school. Clinical staff including GPs had a stand at the school for a day during the school fete. They offered weight, blood pressure and blood sugar checks and health promotion and healthy eating advice to the public.

However there was also an area where the practice needed to make improvements. The provider should:

- Review the recruitment policy to ensure it reflects current regulatory requirements.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. 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 (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the 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 average or higher than others nationally for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population

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and engaged with the NHS Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they 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. There was evidence of learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

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

Families, children and young people

Good

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

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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 reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

People experiencing poor mental health (including people with dementia)

Good

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

The practice offered structured reviews of all patients with severe and enduring mental health conditions with at least annual reviews of their physical, social and mental health, medicines and revision of their agreed care pathway. A weekly counselling service was also

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available at the practice and patients could be referred to them by the GP. A community psychiatric nurse and social worker were also attached to the practice to support patients with poor mental health and dementia related illnesses.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection. Four patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient told us they felt they were not always listened to during their consultation with GPs.

We received 36 completed comment cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. All patients said the staff treated them with dignity and respect.

We spoke with a representative of the patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. They told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes to them and listened to any concerns they had.

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

We reviewed the most recent data available for the practice on patient satisfaction. This was the information from the national GP patient survey and a patient survey undertaken by the practice in October 2013 that was completed by 250 patients. This represented 3.11% of the practice population. The evidence from these sources showed that the majority of patients were satisfied with the service offered by the practice. For example, data from the national patient survey showed that 91% of patients would recommend the practice. This result was above the national average. In the practice survey 114 patients rated the practice overall as excellent, 91 as very good and 30 as good.

Areas for improvement

Action the service SHOULD take to improve

Review the recruitment policy to ensure it reflects current regulatory requirements.

Outstanding practice

There were examples of outstanding practice at Stanmore House Surgery as follows:

The practice provided an Xpert Diabetes Programme (XDP). The aim of this programme was to provide patients with the knowledge, skills and confidence necessary to self-manage their diabetes. An audit had been completed by the nurse practitioner in November 2014. This audit looked at 131 patients who had attended the course in 2012 to 2014. The outcome showed that the average HbA1c (blood sugar) levels reduced post attending the XPD; 73.3% of patients had a reduced HbA1c and 58.8% managed to maintain this reduction in blood sugar levels.

Data reviewed showed that Wyre Forest Clinical Commissioning Group (CCG) had the highest rate of excess weight in four to five year olds out of the six Worcestershire districts. This summer the practice was involved in a community engagement exercise at a local primary school. Clinical staff including GPs had a stand at the school for a day during the school fete. They offered weight, blood pressure and blood sugar checks and health promotion and healthy eating advice to the public.

Stanmore House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Stanmore House Surgery

Stanmore House Surgery is located in Kidderminster. It provides primary medical services to patients living in Kidderminster, with some patients in Trimpley, Wolverley, Blakedown, Harvington, Summerfield and Shenstone.

The practice has four GP Partners (three male and one female) and two salaried GPs (one male and one female). The practice also has a practice manager, a nurse practitioner, two practice nurses, two healthcare assistants, reception and administrative staff. There are 8193 patients registered with the practice. The practice is open from 8am to 6.30pm Monday to Friday. Patients can access the service for appointments from 8am and on line booking is also available. The practice offers extended hours Tuesday mornings 7am to 8am and Monday and Wednesday from 6.30pm to 8pm each week. The practice treats patients of all ages and provides a range of medical services. Stanmore House has a higher percentage of its practice population in the 65 and over age group than the England average.

Stanmore House Surgery provides 92 GP sessions and 28 nurse sessions each week.

Stanmore House has a Personal Medical Services contract. The PMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is an approved GP training practice. This means that qualified doctors who want to work in general practice spend 12 months working at the practice as registrars as part of their three years specialist training to become a GP.

The practice provides services for patients with respiratory problems, diabetes and heart disease. It offers child immunisations, influenza and travel vaccinations and family planning services. The practice also provides a minor surgery and a phlebotomy (taking blood) service. Stanmore House does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

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

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.

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

Detailed findings

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We received information from the Clinical Commissioning Group (CCG) and the NHS England Local Area Team (LAT).

We carried out an announced inspection on 3 December 2014. During our inspection we spoke with four GPs and one GP registrar (a GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice). We spoke with one nurse practitioner, one practice nurse, the practice manager, one healthcare assistant who was also a phlebotomist (specialised healthcare assistant who collect blood from patients) and two reception staff. We spoke with five patients who used the service about their experiences of the care they received. We reviewed 36 patient comment cards from patients sharing their views and experiences of the practice. We also spoke with a representative from the patient participation group and managers from three care homes who received a service from the practice. We also looked at procedures and systems used by the practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

We saw that the practice had robust systems in place to assess and monitor the consistency of their performance over time. We saw records which showed that multiple sources of information were used by the practice to check the safety of the service and action was taken to address any areas in need of improvement. These included significant events (SEs) and complaints. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events and were made available to us. Staff told us they were responsible for completing significant event forms, and significant event audits or analysis were carried out each time there was a patient safety incident. Staff told us they were informed of the outcome from these and debriefed at the weekly meetings. They also said they received a copy of the meeting minutes. An action plan would be put in place to ensure improvements were made so that the incident did not happen again.

The practice had a designated lead for the management and coordination of any SEs. The SEs lead told us all incidents were written on a wipe board in the administrative teams' office and were discussed at the weekly clinical meetings. We saw minutes of a meeting dated 2 December 2014 which showed that eight SEs were discussed. All practice staff were invited to attend these meetings. Discussion with GPs and staff confirmed this. The senior GP partner told us that SEs were also discussed at the weekly business meetings. We tracked five incidents and saw they were comprehensively completed with regard to content, subject matter and procedures followed. For example, a patient with suspected chickenpox had not been isolated when they attended the practice. An alert had been placed in the patient's records to isolate them, however as they used the self-check-in facility this was not picked up by staff. This was discussed at a partners' meeting. The learning recorded was the reception staff were to inform patients not to use the self-check-in on arrival when an appointment was booked for patients with a potential infection where there was a need for isolation. An action plan was put into place to ensure staff were aware of the practice isolation protocol. Discussion with staff confirmed this protocol was in place and a room was made available for patients who were potentially infectious. The GP partner told us the practice openly shared significant event information with all staff and they operated a 'no blame' culture of reporting. This was confirmed in discussion with clinical and administrative staff.

National patient safety alerts, medical devices alerts and other patient safety alerts were disseminated by email to practice staff. Staff told us they received these by email from the practice manager. The senior GP partner told us these were discussed at the weekly practice meetings. We saw minutes of a meeting dated 02 December 2014 which confirmed this. A clinician showed us how the practice responded to medicine safety alerts. We saw patients on these medicines were identified on their computer system. These patients were either recalled to attend an appointment for medicine review or a letter was sent to these patients. Clinical staff told us that they received a copy of any safety alerts from the lead clinical nurse. They then checked the medicines or medical devices stock and reported back to the lead clinical nurse with the outcome of their checks. This ensured that safety alerts were followed up and appropriate action taken.

Reliable safety systems and processes including safeguarding

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

Good

Are services safe?

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to level three (advanced), and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures through the practice's intranet site. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. For example, a staff member told us they had reported to the safeguarding lead GP an incident where a child had failed to attend two appointments for immunisations. They told us the safeguarding lead GP had following this up appropriately. The safeguarding lead GP told us they had referred an adult patient where the relative had raised concerns about their carer. The safeguarding lead GP told us this case had been reviewed and the allegations were found to be unfounded. Staff told us any safeguarding concerns were discussed at the weekly practice and business meetings. We saw recent minutes of these meetings which confirmed this.

Patients' individual records were managed in a way that helped to ensure their safety. Records were kept on an electronic system called EMIS, which collated all communications about the patient including scanned copies of communications from hospitals. Staff told us that the system was used to highlight vulnerable patients which ensured staff were alerted to any relevant issues when patients attended appointments. We found that GPs used the required codes on this electronic case management system to ensure risks were clearly flagged and reviewed. We saw that the practice's safeguarding children policy, last reviewed on 3 November 2014, clearly stated what codes staff must use on this electronic case management system to highlight vulnerable children.

The safeguarding lead told us they met with the health visitor on a weekly basis. They also attended bi-monthly multi-agency safeguarding meetings to discuss patients subject to safeguarding plans.

A chaperone policy was in place and information about the service was available on the display screen in the waiting room and in the practice leaflet. A GP told us they offered this service to patients where applicable. Staff told us that the GPs and nurses always asked patients whether they required a chaperone when they received any intimate treatment. This included children when a parent was present. Discussion with patients confirmed this. Staff told us that chaperone duties were carried out by named staff. The practice manager showed us the list of staff that were trained to carry out these duties. A GP and a nurse clinician told us they had a list of staff they were able to call upon if they required a chaperone. Records showed these staff had received chaperone training. Discussion with staff confirmed this.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring refrigerated medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. We saw that there was a thermometer in the room where non-refrigerated medicines were stored. However, there was no system in place to show they monitored that these medicines were kept within the temperature guidelines recommended by the manufacturer.

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

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

One member of the nursing team was qualified as an independent prescriber. This nurse prescriber told us they received regular supervision and support in their role. The practice manager told us the nurse prescriber had a named GP who acted as their mentor.

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

Good

Are services safe?

All prescriptions were reviewed and signed by a GP before they were given to the patient. Staff described and showed us the systems in place for the safe storage and monitoring of prescription pads to prevent them from being stolen and used inappropriately.

The GP medicine prescribing lead told us they had weekly visits from a pharmacy advisor who looked at their prescribing and suggested changes where applicable. The practice had a higher that national average of patients aged 65 and over. Despite this, the practice was below target for prescribing. The lead nurse told us any medicine changes were reviewed by the pharmacy advisor. Medicines were discussed at the quarterly prescribing meetings and at the weekly clinical meetings held at the practice.

Cleanliness and infection control

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

An infection control audit had been carried out in July 2014. An action plan was in place for any shortfalls that were highlighted. For example, sharps bins not labelled appropriately and the lack of posters for staff to ensure the correct colour waste bags were used. We saw that this had been followed up and actioned. Minor surgery was carried out at the practice. We saw that single use instruments were used and they were in date. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

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

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections. A legionella risk assessment had been completed dated 14 February 2014. Legionella risk assessments are required to identify and assess the risk of exposure to legionella bacteria from work activities and water systems on the premises and to consider any necessary precautionary measures. Water used by the practice came straight from the main water system as the water storage tanks had been removed. This reduced the risk of legionella.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance records and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the equipment had been tested in January 2014. We saw evidence of the calibration of relevant equipment, for example weighing scales and blood pressure monitoring equipment. A certificate of calibration showed the next test was due in August 2015.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. This included all of the information required under Regulation 21, Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. For example, proof of identification, references, qualifications and registration with the appropriate professional body. We saw that Disclosure and Barring Service (DBS) checks had been completed for all staff who worked at the practice. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children.

Patients were cared for by suitably qualified and trained staff. There was a system in place that ensured health professionals' registrations were in date. The practice paid the annual registration fees for all nursing staff who worked at the practice. We looked at a sample of recruitment records for clinical staff. These showed that pre-employment checks had been done to ensure that clinical staff held up to date qualifications with their governing bodies such as the General Medical Council

Good

Are services safe?

(GMC) and Nursing and Midwifery Council (NMC). This ensured that GPs and nurses were registered with their appropriate professional body and were considered fit to practice.

The practice had a new employee recruitment, selection, interview and appointment policy. This protocol dated December 2012 set out the standards it followed when recruiting staff. This did not align with the checks that were being done by the practice prior to the appointment of staff. We saw that the policy did not make reference to all of the information required to be obtained as required under Regulation 21, Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. For example, the policy did not refer to the need to obtain a full employment history for all staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. Discussion with the practice manager confirmed this. There was also an arrangement in place for members of staff, including GPs, nursing and administrative staff to cover each other's annual leave. We saw that this expectation for staff to cover annual leave was written in their contracts.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. For example we saw that internal fire system checks had last been completed on 21 and 28 November 2014. The practice manager told us a new fire detection and alarm system had been installed at the practice in August 2013. We saw that quarterly checks were completed by an external contractor. The fire system had last been inspected on 2 October 2014 and no issues were identified. We saw an electrical installation certificate that showed the electrical distribution board had been replaced in May 2014 to ensure the electrical safety at the practice.

The practice also had a health and safety policy that was last reviewed on 29 May 2014. We saw this policy covered areas such as needle stick injury, manual handling, equipment testing including calibration and immunisations for staff. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. The practice were contracted by Wyre Forest CCG to provide an additional four hours each week for appointments due to winter pressure. The practice provided seven hours each week. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews, and followed up if they did not attend. Discussion with patients and care managers for three care homes confirmed that the practice provided this service.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. A GP gave an example of how they responded to patients experiencing a mental health crisis. For example, they had access to a local trust community psychiatric nurse who was attached to the practice. They also demonstrated the provision of rapid access for patients to the Improving access to psychological therapies service (IAPTs) that was also provided by the local trust. (IAPTs is a programme that supports the implementation of National Institute for Health and Clinical Excellence (NICE) guidelines for patients suffering from anxiety and depression). The practice also provided a weekly in-house counselling service by a trained counsellor that was funded by the Clinical Commissioning Group (CCG). CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

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

A service continuity plan and risk assessment was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated with regard to their likely impact on patients and the continuity of the business. Risk areas covered the computer systems, personnel, clinical and the premises. For example, risks identified included power failure, adverse weather, loss of key staff, access to the building and clinical risks such as infection, epidemic and pandemic. The document also contained relevant contact details for staff to refer to. For example, contact details of the electric and gas service suppliers to contact in the event of failure of these services. Copies of this plan were held off site by the four GP partners and the practice manager. They could also access the plan through their computer systems when off site. This plan had to be put into use in September 2013 when contractors found asbestos in the cellar at the practice. The practice moved out of their premises the same day (Friday), notified their patients and set up ready to see patients in another practice from the Monday of the next week.

An internal fire risk assessment had been undertaken. This had been reviewed by the fire brigade in 2013. They had recommended the fire door on the stairs to the first floor was kept shut at all times. We saw this had been actioned by the practice. We saw records that showed staff were up to date with fire training. Regular fire evacuation drills were undertaken with the last one recorded as taken place on 25 November 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment was delivered in line with current legislation and recognised best practice. The GPs confirmed they received information regarding the National Institute for Health and Care Excellence (NICE) guidelines via email and these were used as a point of reference. A GP told us the GP registrar presented any new guidance at the weekly clinical meetings. We saw minutes of a clinical meeting dated 30 September 2014 where they had discussed the use of alternative medicines for anxiety. GPs told us they reviewed relevant updates for their lead areas. For example, diabetes, asthma and dermatology (skin conditions). Minutes we saw showed that any new clinical guidance was also discussed at the weekly partner meetings. The nurse practitioner told us that clinical discussions took place weekly at the partners and clinical meetings. (A nurse practitioner is a registered nurse who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice beyond that of a registered nurse).

The GP medicine prescribing lead told us they had weekly visits from a pharmacy advisor who looked at their prescribing and suggested changes where applicable. The practice had a higher than national average of patients aged 65 and over. Despite this, we saw Clinical Commissioning Group (CCG) data which showed the practice were below target for prescribing, which was viewed as good practice. The lead nurse told us any medicine changes were reviewed by the pharmacy advisor. Medicines were discussed at the quarterly prescribing meetings.

Patients with long term conditions received an annual needs assessment. Staff told us patients were encouraged to be involved with these. GPs told us they lead in specialist clinical areas. For example, dementia, palliative care and chronic obstructive pulmonary disease (COPD). In their practice presentation they told us they encouraged discussion and sought advice amongst the clinical team at the practice. The GP Registrar told us they were never embarrassed to seek help and support from the clinical team.

Every patient over 75 years had a named GP, this included patients who lived in the care homes the practice provided support to. Practice data showed that they had completed 221 care plans for patients over 75 years of age since July 2014. The practice started with inviting patients over 75 years who had not seen a GP for over 12 months; 73 patients were invited, seven declined. Data showed that 100% of patients in this period had care plans in place. We spoke with representatives from three care homes. They confirmed that needs assessments were completed when required. They told us weekly visits were made by a named GP. They told us it was a good practice and that the GPs worked with the staff at the homes to ensure people got the best care possible.

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

A GP told us there was a community 'buddy system' where they could refer patients and carers so that they could be supported to access appropriate social care agency groups. For example, carers and voluntary agency groups such as Citizen's Advice Bureau.

Management, monitoring and improving outcomes for people

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

The practice had a system in place for completing clinical audit cycles. An example of a completed clinical audit

Good

Are services effective?

(for example, treatment is effective)

included an audit of referrals. This was to monitor the efficiency of the patient referrals from the consultation date, to the letter being processed for referral. We saw that this audit was first completed in October 2012 and annually thereafter. The most recent audit was completed in September 2014. Minutes of a clinical meeting dated 21 October 2014 showed the outcome was shared with the practice team. This showed a safe track record over time in managing referrals and improved outcomes for patients; they had achieved 96% of referrals on time compared to 94.5% the previous year. In the last quarter for 2014 ending September, the practice referred 99% within their designated time frames.

We saw that the GPs analysed and audited information post patient death. A GP told us this was used as a learning opportunity to review care, communication and internal policies. We saw that this was discussed at the weekly clinical meetings.

An Xpert Diabetes Programme (XDP) was run by the advanced nurse practitioner at the practice and the lead GP for diabetes. This was a six week structured group based education programme for patients with diabetes that took place on a Tuesday evening at the practice. The lead GP told us they had received a good response to this programme by patients. The aim of this programme was to provide patients with the knowledge, skills and confidence necessary to self-manage their diabetes. An audit had been completed by the nurse practitioner in November 2014. This audit looked at 131 patients who had attended the course in 2012 to 2014. The outcome showed that the average HbA1c (blood sugar) levels reduced post attending the XDP; 73.3% of patients had a reduced HbA1c and 58.8% managed to maintain this reduction in blood sugar levels. The summary of patient feedback showed that patients had found this programme informative and had helped them in their self-management of their diabetes.

There were specialist lead GPs at the practice that were involved in the management of patients with long term conditions such as diabetes, heart disease and asthma. There were also GP clinical leads for safeguarding, learning disability, palliative and dementia care. The senior partner specialised in dermatology (skin conditions) and also worked at the local hospital in this specialism. Due to the expertise at the practice for the management of diabetes by a named GP and the nurse practitioner; the practice was able to be involved in insulin initiation as part of their contract with NHS England. (Insulin helps the body use or store the sugar it gets from food). This enabled patients to be started on insulin without being referred or admitted to the hospital.

GPs at the practice undertook minor surgical procedures in line with their registration and NICE guidance. For example removal of lumps such as cysts. We saw that staff were appropriately trained and carried out clinical audits on their results which were used for learning. We saw a minor operations audit dated July 2014 and actions were identified from this audit. For example, post-operative pain. The action stated was to ensure pain relief medicines were prescribed or advisory medicines were discussed with the patient. We saw that this action plan was followed up in November 2014 which showed implementation of the actions to improve the patient experience.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending courses that the practice saw as essential training, such as annual basic life support. A good skill mix was noted amongst the GPs, with two having additional diplomas in female reproductive medicine and pregnancy, two in family planning, and one with a diploma in child health. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. One GP was validated on the day of the inspection. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical

Good

Are services effective?

(for example, treatment is effective)

staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

The practice manager told us the GPs were flexible with their hours, and would increase the number of hours they worked to accommodate the needs of the service. The practice nurses told us they were able to cover annual leave when colleagues were away. Other staff who worked in the practice were organised into teams, for example reception staff and administration staff. This enabled flexible staffing levels, whereby staff would cover any shortfalls. Staff told us that the practice manager would provide cover as and when required.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We saw that the most recent of these were done in September and October 2014. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example the Xpert diabetes and infection control update courses. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered adequate appointment times and had access to a senior GP throughout the day for support. Feedback from the GP registrar we spoke with was positive.

Practice nurses and nurse practitioners had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, for the administration of vaccines, cervical cytology and nurse prescribing. (Cytology is the examination of tissue cells from the body). Those with extended roles such as the nurse practitioner cared for, reviewed and made referrals to other clinicians for patients with long-term conditions such as asthma, chronic kidney disease (CKD), diabetes and coronary heart disease (CHD). They were supported by designated clinical lead GPs. We saw that group clinical meetings were held weekly and the last one was held on 2 December 2014.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The practice had a system that identified the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. Individual GPs were responsible for looking at their own patients' information. If they were away that day, the information was reviewed by another GP who was their designated 'buddy'. All staff we spoke with understood their roles and felt the system worked well. We were told there were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

A GP and the practice manager told us about the systems they had in place to effectively manage both urgent and routine clinical referrals to secondary care and other health and social care professionals. Staff were able to recognise urgent referrals as a red tape was used for dictation equipment if the referral required processing the same day. Non-urgent referrals were sent within three days of seeing the patient. Minutes from a clinical meeting dated 30 September 2014 showed that staff were reminded of the process for urgent referrals. An audit dated September 2014 showed that in the last quarter for 2014 ending September, 99% of the practice referrals were sent within their designated time frame of three days.

The practice held multidisciplinary team meetings regularly to discuss the needs of complex patients, such as those with end of life care needs or children subject to a safeguarding plan. These meetings were attended by district nurses, social workers and palliative care nurses. Decisions about care planning were documented in individual patient records. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

Training records showed all members of staff had completed training about information governance. This helped to ensure information about patients held by the practice was dealt with safely and with due regard to patients' rights.

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

Good

Are services effective?

(for example, treatment is effective)

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

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

Consent to care and treatment

We saw that the practice had policies on consent and assessment of Gillick competency of children and young adults. (These help clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment). We saw a policy about the Mental Capacity Act (MCA) 2005 assessment and guidance that was last reviewed in December 2013. (In circumstances where patients' lack capacity to make some decisions through illness or disability, health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 to ensure that decisions about care and treatment are made in patients' best interests). We saw examples of where the guidance had been put into practice and had been signed off by the GPs. Clinical staff told us that patients had a choice about whether they wished for a procedure to be carried out or not. For example, a health care assistant told us how they would talk through the procedure when they took blood samples from a patient, if they were anxious or uncertain. They told us they would discuss any concerns or anxieties they had. We were told that if the patient was unsure and needed more time to consider the procedure this was agreed with them. A new appointment would be made for them to return to the practice to allow them more time to make their decision.

GPs told us they undertook training updates for MCA. Training records showed that clinical staff had undertaken consent and capacity training in 2014. Staff spoken with had a good understanding of the key parts of the legislation and were able to describe to us how they implemented it in their practice.

Staff told us the patient always came first and they were encouraged to be involved in the decision making process. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

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

We saw examples of consent forms that had been completed. We saw a consent audit had been completed in December 2014. We saw that the findings were that consent had been recorded on patients' notes. However, written consent had not been obtained for cryotherapy, joints injections and cyst incisions. The action plan was to address this immediately with clinicians that carried out these procedures. (Cryotherapy is the application of extreme cold to destroy abnormal or diseased tissue). Staff who acted as a chaperone told us the process they had seen GPs follow to obtain written consent from patients' prior to the insertion of family planning devices. Staff told us these consent forms were then scanned and put on the patients' electronic notes.

Patients with learning disabilities and patients with dementia were supported to make decisions through health action plans which they were encouraged to be involved in. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw examples of records that showed health action plans were in place and that reviews had been carried out. A GP told us that they also carried out opportunistic screening of patients with dementia. We spoke with two care managers for care homes for patients with dementia and learning disabilities that the practice provided a service for. They told us a named GP undertook a mental and physical review,

including medicines of all of their patients annually, or more often if the need arose. They confirmed that health action plans were in place for all patients with a learning disability.

Health promotion and prevention

It was practice policy that all new patients registering with the practice were asked to attend a health check with one of the GP partners. This included the completion of a health questionnaire.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included: an Xpert diabetes programme, insulin initiation for patients newly diagnosed with diabetes, warfarin initiation for patients with blood clots, travel advice and vaccinations and family planning. We saw patient self-care was promoted by the practice. For example, there was a Pod. This Pod was a secure computer system which was able to record patient data and take readings such as weight and blood pressure measurements. This data was then emailed to their named GP. Patients also had a print out of the results. We saw there were clear instructions to guide patients on how to operate the equipment. Staff told us they were also available to assist patients to use the Pod upon request. Clinical staff told us they intended to use this equipment prior to consultations particularly for patients with long term conditions. This would enable the GP or nurse to have key information available at the beginning of the consultation. It then gave them more time during the appointments to talk with the patient about their health. A health promotion board was available in the reception and waiting room areas.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was in line with the average for the local CCG. We saw that the autumn practice newsletter promoted and invited all children aged two to four and 11 to 13 to attend the practice for a nasal flu vaccination. The practice offered a full travel vaccination service including yellow fever.

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

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

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

Patients with a learning disability (LD) received an annual health assessment. We saw these health action plans were usually done by a named GP with the assistance of a practice nurse. The practice had a higher than average population of patients with a learning disability. Data showed that 74 patients were on the LD register and 16 reviews had been completed so far this year. The practice manager told us the remainder would be completed by 1 April 2015. There were systems in place that ensured babies received a new born and six week development assessment.

The practice offered structured reviews of all patients with severe and enduring mental health conditions with at least annual reviews of their physical, social and mental health, medicines and revision of their agreed care pathway. A weekly counselling service was also available at the practice and patients could be referred to them by the GP. A community psychiatric nurse and social worker were also attached to the practice to support patients with poor mental health and dementia related illnesses.

For antenatal clinics, reception staff directed patients to the nearest children's centre in order to make an appointment with a midwife.

The practice offered a confidential and comprehensive family planning service. These GPs were able to fit coils and implants as part of the family planning service.

Patients over the age of 40 were offered a health check. The nurse practitioner told us a monthly search was done by date of birth. These patients were then invited to attend for a health check by letter or telephone call.

Data showed that Wyre Forest Clinical Commissioning Group (CCG) had the highest rate of excess weight in four to five year olds out of the six Worcestershire districts. The

Good

Are services effective?

(for example, treatment is effective)

nurse practitioner told us they offered individual advice for patients. For example diet and food diaries. This summer they were involved in a community engagement exercise at a local primary school. Clinical staff including GPs had a stand at the school for a day during the school fete. They offered weight, blood pressure and blood sugar checks and health promotion and healthy eating advice to the public.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This was the information from the national GP patient survey dated 2013 and a patient survey undertaken by the practice in October 2013 that was completed by 250 patients. This represented 3.11% of the practice population. The evidence from these sources showed that the majority of patients were satisfied with the service offered by the practice. For example, data from the national patient survey showed that 91% of patients would recommend the practice. In the practice survey 114 patients rated the practice overall as excellent, 91 as very good and 30 as good.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 36 completed cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. All patients said the staff treated them with dignity and respect. We spoke with five patients on the day of our inspection. Four patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient told us they felt they were not always listened to during their consultation with GPs.

We saw that consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We heard music was played at a low level in the waiting room to assist in maintaining confidentiality.

Staff told us they worked to ensure patients' privacy and dignity was respected. Staff told us patients were encouraged to stand back from the reception desk and wait their turn to speak with the receptionist. This made sure that each patient was given the respect and privacy they needed. The team leader told us that reception staff could take patients to a nearby room if the patient wished to speak with them more privately. To ensure confidentiality was maintained at all times, no telephone calls were taken by reception staff in the patient waiting area. They were all answered on the first floor of the building which was a staff only area. The five patients we spoke with had no concerns about their privacy and confidentiality whilst attending the practice.

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

Care planning and involvement in decisions about care and treatment

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

In the practice survey 113 patients felt the GP was excellent at listening to them, 72 responded very good and 24 good. In response to the GP involving them in decisions that related to their care 91 responded excellent, 98 very good and 36 good.

The nurse practitioner told us all patients with long term conditions had a written care plan. They told us patients were actively encouraged to take part in care planning activity and to set goals.

Staff told us that translation services were available for patients who did not have English as a first language. The check-in facilities at the practice were automated and multilingual. Information on the practice website stated that some of the GPs spoke German, Swedish, Hindi, Kannada, Malayalam and Tamil.

GPs told us they undertook training updates for MCA. Training records showed that other clinical staff had

Good

Are services caring?

undertaken consent and capacity training in 2014. Staff spoken with had a good understanding of the key parts of the legislation and were able to describe to us how they implemented it in their practice. Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us the patient always came first and was involved in decision making. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multi-Disciplinary Team (MDT) approach with district nurses; palliative care nurses hospitals and day hospice support with a specialist palliative care clinic. Monthly palliative care meetings were held by the lead GP for palliative care and the district nurses. Training records showed that all of the GPs had undertaken recent training for end of life care. GPs told us that a higher percentage of patients died at home in the Wyre Forest than other areas of the country. A GP told us they were of the opinion that this was due to the availability care and support provided in the community.

Patient/carer support to cope emotionally with care and treatment

GPs and nursing staff told us they worked closely with Macmillan nurses and the local day hospice to provide care and support for patients who needed end of life care and support for relatives. Discussion with staff confirmed this. Nursing staff we spoke with had a good understanding about the impact of bereavement on patients' families. They told us about the local services they could refer patients to for support. For example, Worcestershire Bereavement Support and CRUSE.

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

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

The practice had an active patient participation group (PPG) to help them to engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The PPG were involved in the production of, collation of feedback and response to the practice's patient surveys. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patient surveys. For example, the outcome of the October 2013 survey showed that they had installed a new telephone system to enable patients to direct themselves to the appropriate service. To support working patients the practice further promoted their commuter surgeries and the availability of telephone advice from GPs.

The practice had a low turnover of staff which enabled a good continuity of care. Stanmore House Surgery had been at the current premises for 25 years, although the GP partnership had been established for over 40 years. Appointments could be made with a named GP or nurse.

All older people had a named GP who had overall responsibility for their care. This included the review of their conditions that might involve a home visit to see these patients. Patients who required a longer appointment could book these with reception staff.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some patients faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us that usually the patient was accompanied by a family member or friend who would translate for them. Staff told us they would arrange for access to a telephone interpreter if required and that information could also be translated via the website. Information on the practice website stated that some of the GPs spoke German, Swedish, Hindi, Kannada, Malayalam and Tamil.

Staff told us there were some homeless patients registered with the practice. Staff told us that no one would be turned away from the practice.

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

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. There was clear signage informing patients where to go. There was a disabled toilet and wheelchair access into and throughout the practice for patients with mobility difficulties. All consulting and treatment rooms were on the ground floor of the building. We saw there was a door bell at the front door at a suitable height to enable patients with mobility difficulties to request assistance from staff as needed. There was a disabled parking space at the front entrance of the practice.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable people who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. For example, where

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients were also identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

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

Equality and diversity training was undertaken by staff in 2013. Staff we spoke with confirmed this.

Access to the service

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

The practice was open from 8am to 6.30pm Monday to Friday. Patients could access the service for appointments from 8am and on line booking was also available. The practice offered extended hours Tuesday mornings 7am to 8am and on Monday and Wednesday from 6.30pm to 8pm each week. Longer appointment times were made available to patients as needed, such as patients with poor mental health, learning disability and mental health reviews and for patients with long term conditions. Patients we spoke with were aware they could book longer appointments with a GP if required. Patients we spoke with were happy with the service provided. All of the patients told us they could access same day appointments if the need arose. The information on the 36 comment cards we received aligned with this information.

Stanmore House Surgery provided 92 GP sessions and 28 nurse sessions each week. The practice manager told us the appointment availability was monitored daily by the team leaders. If further appointments were required they had the flexibility to change telephone consultation slots into face to face consultations and routine appointments could be made available with the duty GP.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. We looked at the complaints log for the last 12 months and found all had been handled and resolved to the satisfaction of the individual patient.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified. The practice manager told us lessons were learnt from complaints and concerns and they were acted upon. For example, concerns were raised by patients in the most recent staff survey about staff attitudes. We saw that staff had received refresher 'front of house' training following this.

The GPs and the practice manager told us that complaints were discussed formally at the weekly clinical meetings. We saw that complaints and compliments were a standard agenda item for these meetings. We saw that the outcome and learning from complaints were also shared with the staff team at these meetings. Staff told us they were aware of what action they should take if a patient complained. Staff confirmed that complaints were discussed at the weekly clinical meetings where all staff were invited to attend. Staff told us they were made aware of any outcomes and action plans from any complaints.

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

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and values were set out in a practice document. This stated the practice was committed to providing personalised, effective and high quality general practice services to meet the health needs of all of their patients.

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

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via their electronic systems. We looked at 12 of these policies and procedures. All 12 policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice had a system in place for completing clinical audit cycles. An example of a completed clinical audit included an audit to monitor the efficiency of the patient referrals from the consultation date, to the letter being processed for referral. We saw that this audit was first completed in October 2012 and annually thereafter. The most recent audit was completed in September 2014. Minutes of a clinical meeting dated 21 October 2014 showed the outcome was shared with the practice team. This showed improved outcomes for patients as they had achieved 96% of referrals on time compared to 94.5% the previous year. In the last quarter for 2014 ending September, the practice referred 99% within their designated time frames.

The practice had arrangements for identifying, recording and managing risks. We saw a number of protocols and risk assessments. For example, fire, needle stick injury and risks to the business. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

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

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. There was evidence of strong team working and support for each other. Records showed that weekly clinical meetings took place and all staff were invited to attend. Staff told us they received minutes from these meetings. Weekly partner meetings were held. The practice manager told us that quarterly partner meetings were also held in the evenings. Staff told us that the GPs, practice manager and team leaders were very supportive.

Staff told us that there was a positive culture and focus on quality at the practice as we saw from the range of meetings held regularly and the policies available to support staff. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual

Are services well-led?

Good

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

appraisals. We spoke with a GP who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

One of the GP partners described the ethos of the practice in their presentation to us. They told us they encouraged discussion amongst the clinical team and sought advice from each other. This was confirmed through discussion with staff.

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

We found the practice to be open and transparent, and prepared to learn from incidents and near misses. Significant events meetings were held where these were discussed. Lessons learned from these discussions were shared with the clinical team. We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken.

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

The practice had an active patient participation group (PPG) to help them to engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. We spoke with a representative of the PPG who explained their role and how they worked with the practice. They told us the PPG had been active at this practice for approximately 15 years, but long before it was a contractual requirement to have one in place. They told us that the group was predominantly retired people, but they had tried to recruit younger members. For example, they had made contact with the local secondary school to try and recruit young adults to the group. The representative told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes in the health economy to them and listened to any concerns they had.

The practice had gathered feedback from patients through patient surveys and complaints received. The PPG representative told us they had met up in January 2014 with representatives of the practice to discuss the results of the October 2013 survey. They agreed and set an action plan for improvements for the following year. We saw that the practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from this survey. For example, the outcome of the October 2013 survey showed that they had installed a new telephone system to enable patients to direct themselves to the appropriate service. To support working patients the practice further promoted their 'commuter surgeries' and the availability of telephone advice from GPs. The practice also actively monitored appointment availability lost through patients failing to attend booked appointments. A text messaging and emailing service was offered as a reminder for patients about forthcoming appointments. Patients had to opt in to use this service.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified. The practice manager told us lessons were learnt from individual complaints and were acted upon. We saw that four comments had been made on the NHS Choices website for 2014. These all provided very positive feedback about the practice and its staff.

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

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

Management lead through learning and improvement

Are services well-led?

Good

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

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

The practice was a well-established GP training practice. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer. A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. We spoke with one of the practice's current GP registrars. They confirmed that they had a named GP trainer at the practice and felt well supported by the whole team.

The practice was committed to becoming a progressive learning environment. Teaching and training was a core part of their work. The practice also provided placements for medical students from Birmingham Medical School.

We looked at the practices summary of significant events. We tracked five incidents and saw they were comprehensively completed with regard to content, subject matter and procedures followed. For example, a patient with suspected chickenpox had not been isolated when they attended the practice. This incident was discussed at a partners' meeting. Learning for reception staff was recorded and actioned. An action plan was put into place to ensure that staff were aware of the revised practice isolation protocol. Discussion with staff confirmed this protocol was in place and a room was made available for patients that attended the surgery who were potentially infectious.