Stanmore House Surgery

Inspection report

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 location	Outstanding ☆
Are services safe?	**Outstanding** ☆
Are services effective?	**Good** ●
Are services caring?	**Good** ●
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Good** ●

Overall summary

This practice is rated as Outstanding overall. (Previous rating 04/2015– Good)

The key questions at this inspection are rated as:

Are services safe? – Outstanding

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Good

We carried out an announced comprehensive inspection at Stanmore House Surgery as part of our inspection programme.

At this inspection we found:

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

•The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines. The practice had carried out 17 audit cycles, including two and three cycle audits.

•Staff involved and treated patients with compassion, kindness, dignity and respect.

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

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

• One of the GPs visited the local primary school to engage with the local community. The GP delivered sessions on Dermatology, Diabetes and healthy eating to raise awareness.

•The GPs would often do teaching sessions for the nurses at the practice on their day off. They had done talks on Thyroid disease and Hypertension amongst others to highlight current NICE guidance and upskill nurses. The nurses found the impact of these sessions very helpful when they carried out weekly ward rounds in the local care homes.

•The Advanced Nurse Practitioner at the practice did some training sessions at one of the local care homes for day staff and night staff. The teaching session was about verification of death. The intention was to confidently verify a death in house so that they did not have to call external agencies in which was kinder for bereaved families.

•The practice proactively identified carers and supported them. There were 316 carers registered with the practice which was 3% of the patient list.

We saw several areas of outstanding practice:

•The practice had an effective approach to managing safeguarding for children and vulnerable adults. This included having a clinical and non-clinical safeguarding lead and reviewing the notes of every new child and their family who registered at the practice. The practice reviewed the notes of all newly registered children and their household contacts every four weeks via a search on the computer system.

•The practice had a very robust system in place for monitoring patients on high risk medicines.

•The practice had an innovative way of dealing with external safety alerts. The practice manager had devised a system on the computer which was colour coded and ensured all clinicians saw every alert. The system also allowed clinicians to comment on the alerts.

•The GPs and other members of the team would walk with the “Stanmore Strollers." This helped to create a community feel and prevent isolation. There were two walking groups: one fast group and one slow group to allow for all abilities. The practice shared examples where patients had returned to this country after a number of years and the Stanmore Strollers helped them to find friends in the community again. They shared an example where a patient had been a carer to their parent. When the parent went in a nursing home they had felt isolated, now they often run the walking group. The practice allowed patients registered with other practices to register as Stanmore Strollers. They would go for refreshments to the local pub after their walk.

•The practice was rated top out of 65 surgeries in Worcestershire for their overall experience of the surgery in the national patient survey.

Professor Steve Field CBE FRCP FFPH FRCGP

Overall summary

Chief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser.

Background to Stanmore House Surgery

Stanmore House Surgery is located in Kidderminster. It provides primary medical services to patients living in Kidderminster and surrounding areas.

The practice has four GP partners and three salaried GPs (a mix of male and female GPs). The practice also has a practice manager, an Advanced Nurse Practitioner, two practice nurses, two healthcare assistants, reception and administrative staff and a practice based pharmacist. There were 9286 patients registered with the practice at the time of our inspection. 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 appointments until 8pm on a Tuesday.

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. There were over 300 patients in care homes registered with the practice.

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

Stanmore House Surgery is an approved GP training practice. Fully qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP. At the time of the inspection the practice had one Foundation Year Two doctor.

The practice also teaches undergraduate medical students from the University of Birmingham. Patients have the option to see the trainees. Every consultation with a medical student is reviewed by a GP.

Outstanding ☆

Are services safe?

We rated the practice as Outstanding for providing safe services. The practice reviewed the notes of all newly registered children and their family members to identify safeguarding issues. A monthly spreadsheet was kept and maintained by the practice. The practice had a very robust system in place for monitoring patients on high risk medicines and a very safe system for managing patient safety alerts.

Safety systems and processes

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

•The practice had comprehensive systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. The practice also carried out in-house safeguarding training to all staff. The last session was carried out in June 2018. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)The practice had a GP who was the safeguarding lead and a receptionist who was also safeguarding lead at the practice. The receptionist also oversaw the majority of scanning documents and therefore could identify safeguarding issues from letters and then forward them directly to the lead GP. The practice had a proactive approach to anticipating and managing risks to people who use services and ensured this was embedded and was recognised as the responsibility of all staff.

•The practice held a safeguarding meeting every six weeks which the health visitors and school nurses also attended. All safeguarding incidents were recorded. The practice had an online system where safeguarding incidents were colour coded depending on whether they had been actioned or were still being actioned. Clinicians updated the log when information was received about the outcome of the referral and pro-actively contacted social services if this information was not received.

•One of the GP partners reviewed the notes of all newly registered children to identify safeguarding issues and also the records of their family members. A monthly spreadsheet was kept by the practice. The reason for this was that the practice felt strongly that children who migrate from one area to another are more likely to remain 'invisible' to health professionals and so are potentially at more risk of harm.

•The practice provided several examples where reviewing the notes of new children and their family members highlighted safeguarding concerns. Examples included a domestic violence incident, two children that were now looked after but had previously been neglected, one child previously on a child protection plan and one child had a safeguarding alert from a previous GP but with no reason indicated. After exploring further the safeguarding lead at the practice realised this was due to the child's carer suffering from poor mental health. The practice took appropriate action to ensure the child's safety.

•The practice reviewed the notes of all the families as soon as they registered to keep abreast of families registering and to know about families who were vulnerable. This meant they did not have to wait for them to book in for something to then become recognised.

•The practice shared an example where they were concerned about children at a local boarding school as they were attending the practice with other students instead of with members of staff. This was escalated to OFSTED and the Local Authority. As a result of the concerns identified by the GP at the practice the procedure was changed and the practice registered patients as temporary residents. They would now always be accompanied by a teacher and parental consent was always obtained.

•The practice had written a DNA policy which was very comprehensive and ensured that if patients did not attend for an appointment this was followed up. This included pregnant ladies and patients from a local children's home which the practice looked after. The DNA policy and the safeguarding policy was aligned. The GP would recall patients, particularly children, if they were worried or if they had missed an immunisation.

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

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

Outstanding ☆

Are services safe?

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

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

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

Risks to patients

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

•Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.

•There was an effective induction system for temporary staff tailored to their role.

•The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.

•Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

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

Information to deliver safe care and treatment

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

•The care records we saw showed that information needed to deliver safe care and treatment was available to staff.

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

•Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

The practice had a practice medicines co-ordinator who had been in post for one year. Their work improved patient compliance and reduced medicine wastage such as stock piling of medicines in patients homes.

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

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

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

•The practice had a system whereby high risk medicines monitoring was checked very closely. Most patients were having blood tests carried out on a three month basis but the results were reviewed every month. Every time a prescription was issued the practice noted that the results had been reviewed in the patient notes. If blood tests were over due then prescriptions were not issued and the receptionists contacted patients. High risk medicines such as methotrexate were only prescribed by two doctors and one doctor covered if both were on leave. For other high risk medicines a monthly search was run to identify all patients who were prescribed these medicines. One of the GPs then reviewed the list to ensure all patients had their monitoring bloods. If not then the medicine was removed so could not be ordered until the blood test had been done. If a medicine was stopped then this medicine went into the past medicine list. A reason as to why this medicine has been stopped was always put onto the screen according to the practice prescribing policy. If a patient requested a medicine from a past list, the practice medicines co-ordinator would notify the GP.

Track record on safety

The practice had a good track record on safety.

•There were comprehensive risk assessments in relation to safety issues.

•The practice monitored and reviewed safety using information from a range of sources.

Outstanding ☆

Are services safe?

Lessons learned and improvements made

Patients at the practice are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.

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

•All staff were open and transparent and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of safety. Significant events were categorised as minor, moderate and significant. The practice had recorded 48 significant incidents in the last year.

•There was an open culture in which all safety concerns raised by staff and patients who used services were highly valued as integral to learning and improvement.

•The practice learned and shared lessons, identified themes and took action to improve safety in the practice.

•The practice acted on and learned from external safety events as well as patient and medicine safety alerts. Alerts were listed on the computer system and the practice manager had devised a system to indicate who had looked at the alert. This was colour coded and the clinicians could make comments on the alerts if this was required. The system ensured that everyone had access to the alerts. All staff were encouraged to participate in learning and to improve safety as much as possible.

Please refer to the evidence tables for further information.

Good

Are services effective?

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

Effective needs assessment, care and treatment

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

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

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

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

Older people:

•Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.

•The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

•Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

•The practice administered flu vaccines. In the last year 2166 patients over the age of 65 were eligible for their vaccines and 1681 (18% of the patient list) had received their vaccines so far.

People with long-term conditions:

•Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

•Staff who were responsible for reviews of patients with long term conditions had received specific training.

•The practice had an effective recall system using a diary system. They had a recall team led by one of the nurses and this enabled clear follow up. The practice sent up to three reminders via text message, email or letter.

•GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

•Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.

•The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. During the inspection we saw the Diabetes template. This included a section on child bearing age and if there was a possibility the patient might be pregnant they were referred to Diabetic clinic for safety. The practice received input from their local diabetes specialist nurse every 12 weeks. This together with the Diabetes audits carried out by the practice led to recent significant improvements in their rates of achieving the target HbA1c levels, improved blood pressure control and lipid management.

Families, children and young people:

•Childhood immunisation uptake rates were above the target percentage of 90%.

•The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care.

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

•The practice's uptake for cervical screening was 78%, which although above local and national averages, was below the 80% coverage target for the national screening programme.

•The practice's uptake for breast and bowel cancer screening was above the national average.

•The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

Good

Are services effective?

•Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. In the last year 2549 patients were eligible for NHS Health Checks and 1518 patients had been invited by the practice. So far 219 health checks had been completed in the last year. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

•The practice offered late night appointments until 8pm every Tuesday evening.

•In addition to these there was extended access appointments from 6.30pm to 8pm Monday-Friday which were held at a local 'hub' with the neighbourhood team made up of five practices.

•The practice offered telephone appointments for patients who requested a call back.

•The practice encouraged patients to sign up for on-line access.

People whose circumstances make them vulnerable:

•End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

•The practice had 42 patients on the palliative care register at the time of our inspection. The practice worked with the neighbourhood team to provide palliative care services and passed the relevant information to out of hours and ambulance services via an electronic system. The practice had palliative care meetings on a monthly basis.

•The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

•The practice had close ties with a local drug and alcohol addiction service and patients could have their consultations with their key worker at the practice to provide care closer to home.

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

•The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.

•When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.

•Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The practice had 167 patients on the dementia register and 92% of the patients had received their annual review in the last year. The prevalence of dementia was the highest for this practice out of all Wyre Forest practices.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

•QOF results were higher than the CCG and national averages. The practice had scored 557 points which was in line with the CCG average and above the national average.

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

•The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

•Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.

•Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. The GPs and nurses presented at the weekly clinical meetings to keep up to date and if there was any new guidance to follow.

Good

Are services effective?

•The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

•The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.

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

•The GPs would often come in on their day off to run teaching sessions for the nurses. During the inspection the Advanced Nurse Practitioner told us how helpful she found the sessions and also how valued it made staff feel. The ANP was unsure about some elements of her job and the extra training had helped her to become more confident in this area.

Coordinating care and treatment

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

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

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

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

•The practice had a 'buddy system' when reviewing test results. This ensured that all results were reviewed on the day they came in.

•Out of hours notifications were reviewed on a daily basis by an allocated doctor on a rota basis. All 111 notifications were reviewed every evening.

•The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

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

•Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.

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

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

•One of the GPs provided information sessions at the local school to raise awareness among children about common diseases such as diabetes and skin conditions. They also took the opportunity to talk to children about healthy eating and set up stands with leaflets to share with the children.

Consent to care and treatment

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

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

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

•The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

•Feedback from patients was positive about the way staff treated people.

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

•The practice gave patients timely support and information.

•The practice's GP patient survey results were above local and national averages in a number of areas. The percentage of respondents to the GP patient survey who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area was 97%compared with the CCG average of 85% and national average of 79%.

•The practice was rated top out of 65 surgeries in Worcestershire for their overall experience of the surgery. It was also in the top 10% of all practices nationally in three out of six questions in the national patient survey.

•During the inspection the practice shared some positive feedback they had received on social media from patients. The feedback they shared praised staff in all departments of the practice.

•The practice felt that they maintained high survey results as there was no barriers to speaking to a healthcare professional and same day appointments were always available. Despite receiving such high survey results the practice was constantly looking at ways of improving results further. They were hoping to use social media more given that they had already started to receive feedback in this manner.

•The practice shared an example where the CRISIS team (team supporting patients suffering with mental health problems) had come to the practice to see a patient urgently. They were at the practice until 8.30pm and the GP stayed with them to offer support.

•Another example we saw during the inspection was that a family was not able to get to a pharmacist after being discharged from hospital. The patient was an end of life care patient and one of the GPs went out the same evening to deliver the medicines to the patient so that they could be comfortable in their own home. We saw a thank you card from the family to the practice during the inspection.

•The practice invited an organisation supporting people with learning disabilities to the practice to see if they were responding to this population group in the best way. The practice had made a change to the way some of its information was presented as a result.

•The practice had an active patient participation group (PPG). One of their suggestions was to set up a walking group every week from the practice. The practice acted on this and ran two walking groups weekly. The GPs and practice manager fully supported this initiative and to the extent of joining the 'Stanmore Strollers' on some of their walks. The walking group had a significant impact on patients in terms of reducing isolation. The practice shared an example of a previously isolated patient who now walked with the group weekly. This person also obtained a job at the local hospice after having built their confidence back with the help of the practice and the Stanmore Strollers. The walking group was also available to patients registered with other practices.

Involvement in decisions about care and treatment

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

•Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

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

•The practice shared an example where a letter was hand delivered to a patient by a member of staff to inform them they had received a cancellation. They could therefore attend for a test the following day. Although the test was not urgent the patient wanted to have this as soon as possible and was very thankful to the practice for this.

Good

Are services caring?

•We saw another example where the Advanced Nurse Practitioner went to meet a consultant out of hours as they were reviewing a patient they had been concerned about.

•The practice proactively identified carers and supported them. There were 316 carers registered with the practice which was 3% of the patient list. The practice had a carer's pack and actively worked with Worcestershire Carers Association. The practice invited the Carers Association to the practice on four separate occasions to meet with patients in the reception area and discuss options available to carers. This encouraged people to register as carers at the practice. When the practice ran flu clinics they invited the Carers Association to attend so that they could advise people here as well.

•The practice's GP patient survey results were above local and national averages for questions relating to involvement in decisions about care and treatment. The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at explaining tests and treatments was 98% compared to the local average of 90% and national average of 86%.

•The practice shared an example where they rang a patient over a bank holiday period to explain some test results to them as they needed to start on medicines immediately. The GP also went to see the patient at home to explain how the new medicines would work.

•The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at explaining tests and treatments was 99% compared to the CCG average of 93% and national average of 90%.

Privacy and dignity

The practice respected patients' privacy and dignity.

•When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.

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

Please refer to the evidence tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as Outstanding for providing responsive services .The practice was rated top out of 65 practices in Worcestershire in the national patient survey for their overall experience of the practice. It was also the highest scoring in comparison to CCG and national averages for access to services. The practice had a walking group every week to encourage people to keep active.

Responding to and meeting people's needs

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

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

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

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

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

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

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

•The practice had a walking group called 'Stanmore Strollers' which met every Tuesday. This encouraged people to keep active and was arranged by the patient participation group. The Stanmore Strollers were predominantly older adults but the practice did advertise to all members of their practice population. The group was open to patients from other practices as well.

Older people:

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

•The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability. They also did chronic reviews at home with the GPs and Advanced Nurse Practitioner (ANP).

•The practice looked after patients in seven care homes; this represented 3% of the practice population. The ANP visited each care home on a weekly basis and the allocated GP visited with the ANP on a monthly basis providing continuity of care.

People with long-term conditions:

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

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

•The practice performed INR testing (how long it takes for blood to form a clot) within the surgery for patients on anti-coagulants. Patients could test at home and provide strips to validated machines then provide telephone feedback for dose adjustment.

•The nurse was involved in rolling out a new App for COPD management. This was being shared with five other local practices.

•The practice targeted diabetes care from care data and subsequently conducted several audits looking at diabetes – the use of GLP-1 agents (medicine used to treat type two diabetes), the use of metformin in renal impairment and identifying patients with undiagnosed diabetes.

Families, children and young people:

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

•All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Outstanding ☆

Are services responsive to people's needs?

•The practice had an in-house clinic for coil fitting, implants, injections and pipelle (endometrial biopsy).

•Post-natal checks were carried out by the practice routinely and they worked closely with the midwives on this.

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

•The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were available on a Tuesday evening.

People whose circumstances make them vulnerable:

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

•The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had 138 patients on this register at the time of our inspection.

•The practice looked after 98 patients with learning disabilities and all patients were invited for their annual review. At the time of our inspection the practice had carried out 74 annual reviews for patient with learning disabilities in the last year.

•The practice looked after patients in two specific care homes for people with learning disabilities.

•The practice was working to recall and monitor patients who had weight loss surgery as indicated in current guidance.

•Patients who were terminally ill were offered appointments with their chosen GP.

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

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

•The practice had provided talks for the patient participation group about dementia to raise awareness and to highlight some of the difficulties patients were facing.

Timely access to care and treatment

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

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

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

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

•Patients reported that the appointment system was easy to use.

•The practice's GP patient survey results were above local and national averages for questions relating to access to care and treatment. The percentage of respondents to the GP patient survey who were 'Very satisfied' or 'Fairly satisfied' with their GP practice opening hours was 95% compared with the local average of 87% and national average of 80%.

•The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment was 96% compared with the local average of 81% and national average of 73%.

Listening and learning from concerns and complaints

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

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

•The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

Leaders have an inspiring shared purpose, strive to deliver and motivate staff to succeed.

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

•Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. There was effective communication on a regular basis to create an open culture.

•The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

•A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. For example the Advanced Nurse Practitioner (ANP) at the practice delivered some training sessions at one of the local care homes for day staff and night staff. The teaching session was about verification of death. The objective was to enable staff to confidently verify a death in house so that they did not have to call in external agencies. The care home staff found this very helpful and it helped the bereaved families.

Vision and strategy

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

•There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.

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

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

•The practice monitored progress against delivery of the strategy.

•The practice was recruiting at the time of our inspection to meet the needs of the increasing patient numbers. They had advertised for an additional ANP and a salaried doctor.

Culture

•The practice focused on the needs of patients. There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement. Staff at all levels were actively encouraged to raise concerns.

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

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

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

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

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

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

•There were positive relationships between staff and teams.

Governance arrangements

Governance and performance management arrangements were proactively reviewed and reflected best practice.

•Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.

Good

Are services well-led?

•Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. The practice took a holistic approach to safeguarding and there were clinical and non-clinical safeguarding leads to maximise its effectiveness. A safeguarding log was maintained and the practice carried out a review of all newly registered children to ensure they missed no safeguarding concerns together with their families' notes.

•The practice had carried out 17 audits in the last two years to improve outcomes for patients.

•The practice have shared their safeguarding approach with other practices in the clinical commissioning group to highlight best practice.

•The practice carried out a weekly analysis of incidents and significant events to identify any trends.

•The practice had a designated team to arrange recalls for long-term disease management. The responsibility was not placed on the patient to remember to attend but on the practice to remind patients.

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

Managing risks, issues and performance

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

•There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. All patients had a named GP and the buddy system meant that people could cross cover for each other and ensure there were no delays.

•The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.

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

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

•The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice had appropriate and accurate information.

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

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

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

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

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

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

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

Engagement with patients, the public, staff and external partners

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

•A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.

•Another GP at the practice was the lead for four other local practices working together in providing extended access appointments to patients.

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

•Innovative approaches were used to gather feedback from people who used services and

the public, including people in different equality groups.

Good

Are services well-led?

•The practice supported the local hospice and raised funds for them.

Continuous improvement and innovation

There was strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences.

•There was a focus on continuous learning and improvement.

•Staff knew about improvement methods and had the skills to use them.

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

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

•One of the nurses was the lead in using a new COPD App and was helping other local practices with this. This App helped patients with COPD to manage their condition better. It contained a symptom tracker, breathing exercises and a medication diary.

The leadership motivated staff to work towards continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. For example the practice had a very proactive approach to taking care of vulnerable adults and children.

Please refer to the evidence tables for further information.