Chaddesley Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 4 December 2014. Overall the practice is rated as good.

We found the practice to be good for providing safe, effective, caring and responsive services and for being well-led. 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. We found the practice provided good care to patients in vulnerable circumstances and to patients experiencing poor mental health.

Our key findings were as follows:

- Every patient we received feedback from was complimentary about the care, treatment and overall experience at Chaddesley Surgery.
- The practice team ensured safe care for patients by identifying potential risks in their systems and clinical processes and taking steps to prevent incidents.
- GPs worked with patients and their families and carers to ensure that they understood how treatments could support their health and that they received the most appropriate care for their needs.
- The practice team was well-led and well managed in all areas. They acted on feedback from the local Clinical Commissioning Group (CCG), their own staff and on the views of patients.

We saw the following outstanding practice :

- Patients with a range of mental health needs described the perseverance of the GPs in locating a treatment option which provided them with the best chance of recovery. The GPs supported patients through treatment, reviewed their progress regularly over time and provided emergency care and treatment when they needed it.

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 the National Institute for Health and Clinical Excellence (NICE) and used it routinely. People's 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 overall for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Staff were motivated and inspired to offer kind and compassionate care. Feedback from patients about their care and treatment was consistently and strongly positive. In particular, patients who had been bereaved described a high level of support from the practice team and patients with a long-term mental health condition told us that the GPs had been thorough in finding the most appropriate treatment options for them. We observed a patient-centred culture. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on, for example patients who had a learning disability were supported with 'easy read' information and documents. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

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

Summary of findings

secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared 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. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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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 people 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 of harm. There was a high level of support for the parents of children who were ill. 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 community nurses and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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

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to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held registers of patients living in vulnerable circumstances including those with a learning disability. GPs had carried out annual health checks for all their patients with a learning disability. They used a template to record and share their findings with these patients. This had been designed to be easy for this group of patients to understand.

Groups of travellers came into the area annually. Their needs were anticipated and appropriate care was offered to them.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It provided information about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. They 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 patients experiencing poor mental health, including people with dementia. Every patient experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The GPs had recognised that their reported incidence of dementia within their patient group was lower than expected and had set up a process to check whether this was an accurate reflection of the health of their older population or an indication that they had not diagnosed some patients with dementia.

Patients with a range of mental health difficulties told us that the GPs worked with them to find treatment options that worked for them. They emphasised how the GPs had sought to find appropriate

Summary of findings

additional support for them, including local voluntary organisations and how much they had appreciated this. We heard that GPs had rigorously pursued treatment options for patients and had enabled patients to move on successfully in their lives.

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What people who use the service say

We spoke with 19 patients during the inspection. We spoke with women and men of different ages. We spoke with some patients who had been bereaved. They told us in detail about the responsiveness of the GPs and the kindness of all the staff during the period their family member had needed end of life care. They told us they had home visits whenever they needed them and they described the level of support then and following the death of the person they loved as remarkable. For some patients their bereavement was some years previously, but they continued to appreciate the care they received then and since and they wanted us to know how much they valued it.

Some patients we spoke with told us about difficulties they had experienced with their mental health or with addiction. These patients told us about the care and support they had received over a long period of time. They emphasised how the GPs had sought to find appropriate additional support for them and how much they had appreciated this. We heard that GPs had rigorously pursued treatment options for patients and had enabled patients to successfully move on in their lives.

We spoke with other patients and their relatives who were parents or carers. They described the professionalism of the GPs and the kindness of all the practice staff. They told us they trusted the GPs to provide the best possible care for children and vulnerable adults.

Forty patients had completed comment cards for us. Their comments were all very positive. These patients told us the practice was excellent and that staff were kind and courteous. They said they could always see a GP when they needed to. They said the care they received was personalised and that they always felt they were listened to and heard.

Outstanding practice

Patients with a range of mental health needs described the perseverance of the GPs in locating a treatment option which provided them with the best chance of recovery. The GPs supported patients through treatment, reviewed their progress regularly over time and provided emergency care and treatment when they needed it.

Chaddesley Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was made up of a GP special advisor, an expert by experience and a CQC inspector who led the inspection.

Background to Chaddesley Surgery

Chaddesley Surgery provides primary medical care to approximately 3,150 patients who live in the village of Chaddesley Corbett and the surrounding rural area in Worcestershire. They are contracted to provide general medical services and some enhanced services by the Wyre Forest Clinical Commissioning Group (CCG).

The practice is housed in a modern building which is well-suited to general medical practice and has facilities for patients with a disability. The practice has two GP partners who are men and one salaried GP, a woman. The practice employs two female practice nurses. A practice manager leads a small team of three reception, administrative and secretarial staff.

Chaddesley Surgery is a dispensing practice with a dispensary located in the building.

Compared with the average practice in England, the overall practice population for Chaddesley Surgery does not experience deprivation. However, we were told that some patients lived in challenging circumstances and that members of a travelling community come into the area annually and use the practice. We were told that they were always made welcome. Older middle-aged people and older people were over-represented in the local Clinical Commissioning Group (CCG) population and in the practice population.

The GPs at Chaddesley Surgery provide the doctor on call service for their patients outside of the regular practice hours, themselves. Information about this, including a number to ring, is given in their practice leaflet.

The CQC intelligent monitoring placed the practice in band four. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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.

Detailed findings

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

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations, including the Clinical Commissioning Group (CCG) for Wyre Forest, to share what they knew.

We carried out an announced visit on 4 December 2014. During our visit we spoke with the two GP partners; a practice nurse; two members of the administrative and reception team and the dispensary manager. We also spoke with staff from other health organisations who were working at the practice that day. We spoke with 19 patients and a carer. We observed how people were being cared for and reviewed a range of documents. We reviewed 40 comment cards left for us by patients.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The practice kept an accident record book and a register of significant events and near misses. Reported incidents and comments and complaints received from patients were reviewed and discussed at significant events meetings. We were told that the practice manager completed a risk assessment exercise annually. They produced a report which identified ways to reduce or manage risks.

We saw that GP partners reviewed national safety alerts and cascaded the information to relevant practice staff.

An area where potential risks had been identified was the volume of letters and discharge summaries received electronically where GPs were required to carry out tasks or change prescribed medication. We saw that to reduce the risk of errors, the GP partners had decided that they would both review the information coming in to the practice. In addition the dispensing manager would review all recommended medicine changes to ensure these were in line with guidance from the Clinical Commissioning Group (CCG) for Wyre Forest.

Safety records, incident reports and minutes of meetings where these were discussed showed the practice had managed these consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff used a specific template to describe the event or incident and identify actions to prevent recurrence. We saw that all members of the practice team who were involved with a significant event were informed about it and asked to attend the subsequent discussion meeting. The practice nurse told us they had recently attended a significant events meeting when a patient's prescription was discussed.

We saw that a significant event had arisen when two patients with the same name and with other similar characteristics had the same procedure. Information from one patient was wrongly ascribed to the other. This was discussed at a multi-disciplinary meeting shortly after the event happened. Action and learning points were recorded including a reminder to check whether similar incidents happened again. Changes were made to the patient record system to ensure similar mistakes were not made.

A significant event which arose when the practice did not have a particular medicine in stock was recorded and shared with appropriate staff. The learning did not focus only on the medicine issue but introduced a wider discussion about the use of a specific medicine and identified areas where GPs should proceed with caution.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. One GP partner was the designated lead for safeguarding children and vulnerable adults at the practice. We saw that they were able to access information about key safeguarding staff within other services from their desk top computer. They described a recent safeguarding referral and told us this had been discussed by appropriate staff within the practice and with local midwives. Children who were subject to a protection plan or child in need plan were identified in their patient record. We were shown an example of how this worked in practice.

The practice was part of a local initiative with the Clinical Commissioning Group (CCG) to develop safeguarding practice. This required GPs to participate in regular multi-disciplinary meetings. We looked at records which confirmed that the GPs at Chaddesley Surgery were attending local meetings with other health professionals to review patients who were at risk of harm.

The staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in and out of normal working hours. Contact details were easily accessible to all practice staff. All the staff we spoke with knew which GP held responsibility for safeguarding.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We saw that GPs had attended safeguarding training at an advanced level. The practice nurses had attended

safeguarding training at an intermediate level and had commenced advanced level training. Other staff had completed safeguarding awareness training for children and vulnerable adults.

We saw that there was a chaperone policy in place which followed national guidance. A chaperone may provide reassurance to patients or support best practice when a clinician carries out an intimate examination of a patient of the opposite sex. A poster in the waiting room explained that this service was available for patients. The practice nurse confirmed that she provided a chaperone service for patients whenever this was required. GPs told us they recorded when they offered a chaperone to patients in their notes.

Medicines management

Chaddesley Surgery is a dispensing practice. Dispensing staff met as a team every week and had regular communication with the GPs and other practice staff. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. The practice nurse confirmed that this policy was followed. We reviewed the daily checks made of fridge temperatures and saw that these were maintained within the recommended temperature ranges.

The dispensary manager told us that 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.

All dispensing staff were aware that prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, these were followed up immediately. There was a repeat prescription policy in place. We were told that every patient who had repeat prescriptions had a face to face consultation with a GP every year. Any error identified would be classified as a significant event. We were told that repeat prescriptions were audited and evidence of the audit trail was kept. The dispensing manager showed us evidence of repeat prescription audits.

There were systems in place for the storage and management of high risk medicines. Controlled drugs were stored securely in a cabinet designed for this purpose. Access to these medicines was restricted.

Regular monitoring took place, in line with national guidance. The dispensary staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Prescriptions for controlled drugs were flagged to ensure appropriate procedures were always followed.

We saw that a significant event had been recorded when a member of the dispensary team had sustained a minor injury when destroying an ampoule of a controlled drug (medicines that require extra checks and special storage arrangements because of their potential for misuse) which had been returned to the surgery. This was discussed by the whole practice team. To prevent a similar incident recurring it was agreed that future supplies of the medicine would be obtained from a different supplier who provided the medicine in a container which made it easier to destroy.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that the practice nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

We found the practice to be visibly clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

A practice nurse told us they were responsible for infection control and that the practice manager audited this area of the practice. The practice nurse confirmed that they had updated their infection control training in 2013.The practice nurse told us that cleaners were responsible for cleaning in the surgery. They kept a record of the work they had undertaken. The practice nurse used a checklist to review the cleanliness.

We saw that personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was a policy for needle stick injury and

for the spillage of body fluids. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

The GPs and the practice nurse told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They said that all clinical equipment was calibrated annually to ensure tests were accurate. The practice nurse cleaned and checked clinical equipment weekly and reported her checks to the practice manager who had overall responsibility for ensuring that all equipment was tested and maintained regularly. We were told that the practiced manager maintained an audit trail of all records associated with equipment at the practice. The equipment we looked at was appropriately calibrated.

Staffing and recruitment

The GP partners told us the practice employed enough staff to ensure the smooth running of the practice and to maintain safe care for patients. They said that the turnover of staff was low and that some staff had been with the practice for a long time. We were told that reception and secretarial staff worked flexibly to ensure that patient services were met. The practice was able to call on a retired receptionist when they needed cover for staff holidays or sickness.

Chaddesley Surgery did not employ locum GPs. As a small practice they were aware of guidance for doctors working alone. At times, appointments were unused to avoid this.

Records we looked at contained evidence that appropriate recruitment checks were undertaken before new staff were employed. For example, we looked at an employment file for a nurse. We saw that their certificate of qualification, evidence of their registration with the Nursing and Midwifery Council, identity checks and two references were in place.

A practice nurse confirmed that tests were undertaken to ensure that clinical staff had appropriate health checks.

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. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions, acutely ill children and patients in mental health crisis. The practice monitored repeat prescribing for people receiving medication for mental ill-health.

Arrangements to deal with emergencies and major incidents

We looked at the business continuity plan for the practice dated January 2014. We saw that it was comprehensive and identified key risks, including damage to the surgery building; the loss of power and the loss of computer systems. We saw that there was a power generator which would ensure that the surgery would have electricity in the event of a power failure. We saw that the business continuity plan included a list of key contact numbers including utility suppliers. It provided clear guidance for staff to follow in the event of an emergency. Copies of the plan were kept off site.

The practice had arrangements in place to manage emergencies. We were told that all members of the practice team received annual training in basic life support. This was confirmed by the staff we spoke with. The practice nurse told us they had also completed training in managing patients who had severe reactions to allergens (anaphylaxis).

Emergency medicines were checked and monitored by the dispensing manager to ensure they were within their expiry date and suitable for use. These included an emergency

Good

Are services safe?

medicines box in every clinical room and a 'grab bag' for use by the GPs. We checked the grab bag and found that the medicines were appropriate for a range of emergencies and were in date.

Emergency equipment was accessible at a central point in the surgery. The practice manager monitored all equipment to ensure that it was appropriately tested and maintained.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GP partners told us they kept the latest clinical guidance on the desk top of their computers in order to access it when they needed to. They told us they used local guidelines for prescribing antibiotics and we saw that this guidance was accessible to view.

We saw a full audit of prescribing a specific antibiotic. In 2012, the GPs had noted that their prescribing of antibiotics was low in general but relatively high in respect of this particular antibiotic. They concluded that their prescribing was not in line with local prescribing guidelines. We saw that this information was disseminated and discussed at a practice meeting. Subsequently they reduced their prescribing of the antibiotic and, at the time of our inspection, were fully compliant with guidelines. In one area of antibiotic prescribing, the practice had performed better than other practices in England. The staff we spoke with and the evidence we reviewed confirmed care was taken consistently to ensure that each patient received support to achieve the best possible health outcome for them.

The GPs told us they took lead roles in specialist clinical areas such as dermatology and ophthalmology but shared the work in most other areas. The practice nurse supported their work. Chaddesley Surgery is a small practice and all members of the practice team have frequent discussions about their work with patients. The GPs told us this supported them in ensuring that patients' clinical needs were regularly reviewed.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and ethnicity was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We looked at a broad range of clinical audits, including an audit of frail and elderly patients as part of a local enhanced service; an audit of patients having cryo-therapy (a technique for freezing skin lesions) and prescribing audits. These were completed audits or part completed audits where the practice was able to demonstrate the developments in patient safety since the initial audit.

In respect of the audit for frail and elderly patients, we read that the practice had recognised it had a lower than expected level of patients diagnosed with dementia. We saw that the practice was actively following up patients aged over 75 for early signs of dementia to ascertain whether this rate reflected the true incidence or whether they had missed signs of dementia.

The practice used the information collected for the Quality Outcomes Framework (QOF), a national performance measurement tool, and other national and local screening programmes to monitor outcomes for patients. For example, 100% of patients aged over 75 years had a named GP of their choice. The practice held registers of patients who had a learning disability, patients who were prescribed medicines for their mental health, patients who needed end of life care and patients who had other complex needs. They had identified patients who were at risk of blood clotting illnesses and used anti-coagulant medicines; patients with diabetes and patients with respiratory disease. The GPs and practice nurses supported all their groups of patients with the specialist care they needed.

The practice also participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area, for example in relation to child immunisations.

The GPs reviewed each other's clinical work. One GP reviewed work undertaken by the practice nurses. In addition peer supervision was available through the CCG. We looked at one GP's record of their peer supervision which had extended thinking and reinforced the message of taking care that all referrals to secondary care were justified. This had been shared with other clinical staff which illustrated the open, learning-focused culture within the practice.

Good

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system used by the practice to manage patient information flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and an understanding of best treatment for each patient's needs.

The practice used the gold standard framework for end of life care (GSF). The GSF is a system to improve the quality of palliative care in the community designed to enable patients to receive supportive and dignified end of life care. The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families; it involved patients in making decisions about their care and treatment for as long as possible.

Effective staffing

The three GPs were up to date with their yearly continuing professional development requirements. One GP partner had been revalidated in July 2014 and the other GP partner had a date for their revalidation in January 2016. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

The partner GPs had appointed a salaried GP who was female. This provided greater choice for patients when they needed to see a GP. We found that the GPs at the practice had a broad range of expertise in addition to general medicine. This included neurology, ophthalmology, dermatology, emergency medicine and geriatric medicine.

The two practice nurses had professional registration plus additional training which included equality, diversity and human rights, and clinical training updates. One of the practice nurses was a trained children's nurse which brought this area of expertise to the practice.

We looked at training records which confirmed that all staff had received training in basic life support, health and safety, fire safety and safeguarding at a level appropriate to their role in the practice. Key staff had received training in infection control and the GPs and nurses had received specialist training including understanding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and updates to their clinical training. Dispensing staff had certificates of competence in dispensing and appropriate registrations as pharmacy technicians.

The practice was commissioned to provide a range of enhanced services. We reviewed the local enhanced service for dementia. We saw that participating in delivering the enhanced service required that staff attended training at different levels. We saw that nurses and members of the reception, administration and secretarial team had attended first tier training; nurses attended second tier training which included elements on assessment and early intervention with patients with dementia. The GPs had attended tier three training which included the management of dementia in primary care.

One GP partner completed appraisals for all the other members of the practice team. A practice nurse confirmed that she had an appraisal which identified their learning needs every year. The GPs told us about an instance where they were required to manage staff performance using their relevant procedures.

We saw that senior staff held a monthly practice meeting. We reviewed agenda items during 2013 and 2014 and saw that this was in part a business meeting, used to review financial matters pertaining to the practice and in part a more general planning meeting, to discuss issues such as staffing. We saw that there were additional partners meetings and significant events meetings. The whole practice team did not meet formally, but the members met daily and all staff we spoke with expressed that they were able to raise any matter when they needed to.

Working with colleagues and other services

Information from other health providers including test results, hospital discharge summaries and information from the out of hours service came to the practice through the computerised patient record system. All the information was processed and reviewed by both GP partners to ensure that they had a shared knowledge of events concerning the practice patients and that they did not miss information which was important. They had

Good

Are services effective?

(for example, treatment is effective)

previously recognised that the volume of information presented a risk. They took particular care over information about medicines which needed altering for new prescriptions and involved the dispensary manager in the protocols, which they referred to as the Medicine Optimisation programme. The dispensing manager described excellent team liaison with the practice team.

The practice was working with the CCG on a local enhanced service to reduce avoidable hospital admissions in patients who were aged over 75 years. We looked at information which showed that the practice already had the lowest level of emergency hospital admissions, the lowest attendance at accident and emergency departments and the lowest level of routine admissions, despite having the highest proportion of older patients in the Wyre Forest CCG. The information about their low level of emergency admissions was confirmed by the CCG.

We saw that the practice was involved in a further local enhanced service around safeguarding. Each practice which was taking part was required to attend a minimum of six safeguarding meetings a year with other health and social care staff. We saw records which confirmed that GPs had met with members of other teams to discuss the safeguarding of children.

The GPs met with multi-disciplinary team members, including Macmillan nurses and community nurses to discuss their patients on their palliative care register. We spoke with a physiotherapist, a district nurse and a specialist nurse for older people who confirmed that they had regular meetings with the GPs and practice nurses about their patients and that communication between the services was professional and useful in establishing the best care for patients.

Information sharing

The practice used an electronic patient record system to document and manage patients' care. All staff were trained to use the system. The system enabled scanned paper communications, such as those from hospital, to be saved to patient records. We saw that the GPs reviewed all information which was added to patient records.

The practice used their system to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and efficient manner.

Patients' summary care records contain a list of their medical problems, medication and allergies. In an emergency, the information can be made available to other healthcare providers like hospitals and paramedic services. Patients can choose to opt out of this service and we saw that this was explained in the practice information booklet.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures and intimate examinations, a patient's verbal consent was documented in the electronic patient record. For some procedures, including therapeutic injections, written consent was obtained. We saw a template which outlined the benefits and risks arising from procedures and space for patients to acknowledge that the procedure had been explained to them before consenting.

We reviewed an anonymised patient record which showed that the GP had ensured a patient had completely understood the nature of a procedure before they made a decision to proceed.

We looked at a clinical audit of minor surgery and therapeutic injections. We saw that patient consent was recorded all of the time. The audit showed that providing minor surgery and therapeutic injections at the surgery was safe and effective. It saved patients time in that they did not need to travel to a hospital. It was cost effective in that over a three year period had avoided 120 potential referrals to secondary care.

The consent policy included information about Gillick competence in respect of obtaining consent from children and young people. In respect of children and young people consenting to treatment, GPs must be certain that they are Gillick competent. This means they can understand information about any medical condition they might have or develop and are able to make decisions about their care and treatment based on that understanding. All clinical staff we spoke with understood Gillick competence in respect of children and young people.

GPs told us they had attended training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We found that they were knowledgeable about patients with dementia and patients with a learning disability who might not have the capacity to understand treatment options and make decisions in their own best interests. Patients with a learning disability and those with dementia

Good

Are services effective?

(for example, treatment is effective)

were supported to be involved in developing care plans which set out their health and social care needs and checked that they were not being harmed or exploited in any way.

The template used for the care plans for patients with a learning disability had been developed specifically for this use and used pictures and symbols, to support the patients' involvement in their completion. The care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. We saw that all the patients with a learning disability had been reviewed during the previous year.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The practice identified patients who needed additional support. Any health concerns were followed up, including offering smoking cessation advice for patients who might benefit from this.

GPs cared for patients who were pregnant in partnership with local midwives. A health visitor held a fortnightly clinic at the surgery. The practice nurse provided baby immunisations. There was a clear policy for following up patients who did not attend.

The practice identified patients who needed additional support, for example patients with complex needs, patients who required end of life care and patients with a learning disability. It was pro-active in offering appointments to those patients. Patients over the age of 75 had access to a named GP, as did patients with complex needs and patients receiving end of life care. We saw that the practice had scored better than the national average in respect of the number of patients with dementia whose care had been reviewed in the previous 15 months.

The practice offered NHS Health Checks to all its patients aged 40-75 and a call and recall system was in place. They provided flu vaccinations to vulnerable groups and shingles vaccinations to groups specified in NHS guidance. Private travel vaccinations were available for patients who requested this.

The practice nurses offered a range of health and lifestyle advice, family planning, cervical smears and in conjunction with the GPs some chronic disease monitoring. They saw patients who needed dressings and ear syringing. We saw that in the year ending March 2014, the practice had achieved a take up rate for cervical smears which was close to the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 19 patients during the inspection. They included women and men of different ages, parents of children, young adults, disabled patients and patients who were vulnerable because of a learning disability, mental illness or addiction. We also spoke with patients who had experienced the death of a partner or child. Every patient wanted to tell us about the professionalism of all the practice staff. They said that staff were kind and considerate. They said they were always respectful and that their dignity was maintained at all times. Patients told us they trusted the GPs to provide the best possible care.

Forty patients had completed comment cards for us. Their comments were all very positive. These patients told us the practice was excellent and that staff were kind and courteous. No patient expressed any complaint about the practice. We observed how patients were treated by receptionists. We saw that the reception staff were pleasant and welcoming to patients.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey which indicated that over 98% of patients described their overall experience of the practice as 'good' or 'very good'. We saw that 99% would recommend Chaddesley Surgery to others, compared with a national average of 79%. This was confirmed by the patients we spoke with who told us they would stay in the area in order to remain with the practice.

We spoke with five representatives of the Patient Participation Group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The PPG representatives told us they were an active group who were proud of their involvement in healthcare issues. They told us the practice sent out an annual survey to patients and they were involved in its design and the subsequent analysis of the responses. They told us that the survey for 2013/14 had had a response rate of 110 patients which represented 3.5% of the patient population. They told us that 98% of patients had reported an overall satisfaction rate of 'good' or 'very good'.

We saw that the practice had a leaflet for patients which included information about their right to privacy and how the practice maintained this through their systems and the behaviour of staff. We found that members of the practice team maintained confidentiality, by closing doors to consulting rooms and knocking doors before accessing rooms. We saw that staff at the reception spoke with patients in a discrete manner. We did not overhear any private information. Patients confirmed that their right to privacy and confidentiality was respected by every member of the practice team.

Care planning and involvement in decisions about care and treatment

The patients we spoke with and those who left comment cards for us, expressed that they felt listened to by GPs, nurses and other staff. The patients we spoke with told us they were actively involved in their treatment plans. They said that information was explained in ways they understood and choices were outlined. For example several patients described that a range of care pathways were available for their own or their family member's particular conditions and that they had reviewed the choices with the GP before arriving at a decision about proceeding with treatments. Some patients emphasised that the GPs had researched treatment options for them beyond local services in order to get the best service for them. They told us how much they appreciated this level of care.

Patients with a learning disability and their carers told us they liked to see the GPs and other staff at the practice. We saw that the practice used an 'easy-read' information sheet designed to help patients with a learning disability understand the annual health check they were entitled to. It contained pictures which described the checks that would be made. We also saw the template used to record the health check. This was also in an 'easy-read' format and was designed for patients to be able to monitor their own health measurements as much as possible.

Of patients who took part in the national GP survey, 97% of the respondents who commented on Chaddesley Surgery said that the last time they saw or spoke with a GP, the GP was 'good' or 'very good' at involving them in decisions about their care; 96% said the same in respect of nurses at Chaddesley Surgery involving them in decisions about their care. These levels of satisfaction were above the average levels for England.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The national survey information we reviewed showed that of patients who responded about Chaddesley Surgery 97% responded that GPs and nurses treated them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this survey information. Some of the patients we spoke with had been bereaved. They told us in detail about the responsiveness of the GPs and the kindness of all the staff during the period their family member had needed end of life care. They told us they had had home visits whenever they needed them and they described the level of support then and following the death of the person they loved, as remarkable. For some patients their bereavement was some years previously, but they continued to appreciate the care they received then and since and they wanted us to know how much they valued it.

Some patients we spoke with told us about difficulties they had experienced with their mental health or with addiction. These patients told us about the care and support they had received over a long period of time. They emphasised how the GPs had sought to find appropriate additional support for them and how much they had appreciated this. We heard that GPs had rigorously pursued treatment options for patients and had enabled patients to move on successfully in their lives.

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

We spoke with two nurses and a physiotherapist who were employed by other healthcare organisations and worked closely with the practice to provide additional support and treatment. Each on commented on the dedication of the practice team to provide caring and compassionate treatment for every patient.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The GPs at Chaddesley Surgery described themselves as 'solution-focused'. We found the practice was highly responsive to people's needs and this was confirmed by the 19 patients we spoke with and the 40 patients who left comment cards for us. Patients said the care they received was personalised and that they always felt they were listened to and heard. Those patients who had required a referral to other healthcare providers emphasised that the GPs were thorough in reviewing a range of options with them.

The practice had developed its understanding of its patient population over time. There were systems in place to maintain the level of service needed. For example, the practice reviewed the volume of appointments needed and ensured they had sufficient GP and practice nurse sessions to meet this. When home visits were important to ensure that patients received the care and support they needed, this was factored in.

The NHS England 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. For example the practice was participating in an enhanced service for safeguarding which required them to demonstrate how it worked with other professional staff to protect children and vulnerable adults. We saw minutes of the multi-disciplinary meetings which gave clear evidence of joint working in complex situations.

The CCG confirmed that Chaddesley Surgery knew their patients well and had low emergency admission rates. The CCG told us that in providing a service for a relatively small number of patients, the GPs had retained a lot of the work that is often done elsewhere by a practice nurse. An example of this was the management of patients with long term conditions like diabetes and respiratory illnesses.

We spoke with representatives of the Patient Participation Group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. They told us that the decision to appoint a salaried GP who was female had been influenced by views expressed by patients; they also told us that changes to seating in the waiting room had been made in response to patient feedback.

Tackling inequity and promoting equality

The practice building had been designed as a surgery. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

People who did not have a permanent address, for example seasonal travellers, were able to register with the practice care of the practice address. Staff were able to arrange a telephone interpreting service for patients who did not use English.

Patients who had a learning disability were actively supported to participate in their care and treatment and the GPs provided information for this group which was designed to promote their understanding.

The staff we spoke with had a clear understanding of the values of equality and diversity and sought to ensure these were reflected in every area of the work undertaken at the practice.

Access to the service

The GPs told us they aimed to see every patient who requested an appointment to be seen at a time convenient to them. They managed this by providing pre-bookable appointments between 8.30am and 11am and between 2.10pm and 6pm on four weekdays; between 7.15am and 11am and between 4.30pm and 5.30pm on Wednesdays. They offered an open surgery after 11am each day.

The GPs told us this enabled them to provide appointments for different groups of patients, including patients who were working and school aged children. Longer appointments were also available for people who needed them. Most patients we spoke with told us they did not mind which GP they saw but if they did they could see their preferred GP.

Comprehensive information was available to patients about appointments in a practice leaflet and on the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice website. This included how to arrange urgent appointments and home visits. The GPs provided an out of hours service for their patients and full details about this were included.

The patients we spoke with and patients who left comment cards expressed a high level of satisfaction with the appointments service. They said that when they needed to see a GP, they could always get an appointment. Patients aged over 75 years, patients who had been bereaved, patients with a mental health problem, disabled patients, young adult patients and patients who were parents all told us that the practice was responsive to their needs.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The GPs told us there had not been a complaint about the practice for 13 years. We saw that the practice leaflet explained how patients could make a complaint if they wished to. If any patient made a complaint, it would be managed as a significant event and discussed in the appropriate meetings. The Clinical Commissioning Group (CCG) confirmed that the practice was highly regarded when we spoke with them.

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. The GPs told us they believed in being patient centred. We spoke with three other members of the practice team and found that they supported this value-based practice and were proud to work at the surgery. We saw the GPs' stated vision was evident in literature produced by the practice, including the practice leaflet.

The senior GP partner had set out their plans for retirement and the proposed strategy for the future management of the practice. We saw evidence that this had been discussed with the partner GP and that arrangements were in place to ensure a smooth process of succession when the senior GP retired.

Governance arrangements

The management team at the practice comprised the two GP partners and the practice manager. The partner GPs took specific leadership roles. One partner took responsibility for managing patient information, as the 'Caldicott Guardian'; the other senior GP partner had overall responsibility for the practice and was the lead for safeguarding in respect of children and vulnerable adults. A practice nurse took responsibility for infection control. The staff we spoke with told us they were clear about their own roles and responsibilities. They said they felt valued and well supported and that if they had any concerns they could raise these easily.

We saw that the practice produced policies to set out expectations and protocols, including policies relating to staff. We saw that the GPs had investigated and managed a performance issue following a whistle blowing episode.

Policies and protocols were reviewed regularly and discussed in a range of meetings. Formal practice meetings were held weekly and included the GPs, the practice manager and the nurses. The practice manager met with the administrative and reception staff. Significant event meetings were held and we saw that a range of staff attended these depending on the nature of the event. A full practice meeting was held annually. In addition every member of the practice team described the daily informal contact between staff which had developed over a number of years.

A GP partner told us about a local peer review system they took part in with neighbouring GP practices. Peer reviews were undertaken annually. We saw that the last one for this GP had focussed on referrals to secondary care. The reviewer had concluded that the referrals made had been appropriate.

The GPs had completed a range of audits, both clinical and managerial and used these to monitor the quality of their practice and to identify where action should be taken. For example, we looked at audits in respect of the management of antibiotic prescribing, for identifying dementia and of the outcomes for patients who had minor surgery or therapeutic injections.

We saw that the practice manager had put robust arrangements in place for identifying, recording and managing risks. We saw that risks included those relating to the building and utilities; those which were linked to staffing, such as sickness or holidays and those which related to patients' health. We saw that there were contingency plans to manage risks. We saw that in response to the risk of a power failure, the practice had invested in a generator so that electrical systems could continue to run.

We saw that the GP partners were meticulous in reviewing the financial health of the practice to ensure they could meet patients' needs.

The practice used the Quality and Outcomes Framework (QOF), a national performance measurement tool, to measure its performance. The QOF data for this practice showed it was performing in line with or better than national standards. We saw that one area where the QOF score for the practice had appeared worse than the national average was that it showed a relatively low number of patients identified as having dementia. We saw that the practice had commenced an audit to establish whether they were failing to diagnose patients who had early stage dementia or whether their statistics reflected an older population which had a low level of dementia.

Leadership, openness and transparency

Are services well-led?

Good

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

We saw from records and from speaking with employed staff and staff employed elsewhere and attached to the practice that the practice had an open culture and that all staff were encouraged to raise issues. We saw that when a member of staff had needed to raise a concern, they had been supported to do so, in line with staff management policies.

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

We spoke with five representatives of the Patient Participation Group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The PPG representatives told us they were an active group who were proud of their involvement in healthcare issues. They told us that although there was an absence of negative feedback from patients in the annual surveys, they sought to identify areas where improvements could be made to patients' experience. For example, they referred to improvements in seating in the waiting room, which had been made following their suggestions. They told us they asked about issues like the prescribing of statins for patients with raised cholesterol levels, in order to understand more about this. They said they were prepared to campaign on behalf of fellow patients in areas like the cost of car parking at local hospitals.

We saw that the practice team valued the energy and the challenge provided by the PPG and listened and acted upon their views about improvements for patients. One GP partner told us that their decision to employ an additional female GP had been driven by the views of the PPG.

In addition to the annual surveys, the practice had introduced a 'friends and family' test and had invited patients to fill in comment cards with their views about whether they would recommend the practice to people they knew. The cards we looked at were all very positive about the practice and reflected what the patients we spoke with told us.

The practice had gathered feedback from staff through annual appraisals, regular formal meetings and informal daily contact. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Nurses and a physiotherapist who were based at the practice full or part time told us they were included in training days and always felt able to raise issues and share information about patient care.

Management lead through learning and improvement

A salaried GP told us that the practice supported them to maintain their clinical professional development through training and mentoring. We spoke with a practice nurse who confirmed 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 had staff training sessions. We saw records which confirmed this.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days. For example, issues that could and had arisen when patients had the same name.