St Stephens Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 13 November 2014 as part of our new comprehensive inspection programme.

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

Our key findings were as follows:

· Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.

· There were systems in place to keep patients safe from the risk and spread of infection.

· Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.

· The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

In addition the provider should:

· The recruitment policy should also cover clinical staff and make reference to all of the information required to be obtained as required under Regulation 21, Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. 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 for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

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

Summary of findings

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

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was an active patient participation group (PPG) in place that met three times a year. 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, for example, children and young people who failed to attend appointments or clinics. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with 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 practice offered structured reviews of all patients with severe and enduring mental health conditions with at least annual reviews of their physical and mental

Summary of findings

health, medicines and revision of their agreed care plan. In-house counselling was also available at the practice. Patients with dementia were also offered an annual review.	

Summary of findings

What people who use the service say

We spoke with nine patients on the day of our inspection. Overall patients were happy with the service provided. The majority of patients told us they could access same day appointments if the need arose. Patients we spoke with told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by clinical staff and were given sufficient time during consultations to discuss any concerns. The majority told us their dignity and privacy was respected. Two patients told us that some reception staff were not always polite.

We reviewed the 10 comment cards from our Care Quality Commission (CQC) comments box that we asked to be placed in the practice prior to our inspection. With the exception of one, they were positive about the service experienced. The majority of patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring.

We reviewed the most recent data available for the practice on patient satisfaction. This was the information from the national GP patient survey published July 2014 and a patient survey undertaken by the practice in March 2014 that was completed by 305 patients. The evidence from these sources showed that the majority of patients were satisfied with the service offered by the practice. For example, data from the national patient survey showed that 82% of patients would recommend the practice. The practice was well above average for its satisfaction scores on consultations with GPs; 89% of practice respondents confirmed that the GP was good at listening to them, 92% responded that the GP gave them enough time and 97% had confidence and trust in the last GP they saw or spoke to. These results were all above the national average. In the practice survey, 255 patients were satisfied with the practice, 33 were neutral and 12 were dissatisfied with the practice.

Areas for improvement

Action the service SHOULD take to improve

The practice should review their recruitment policy to ensure that it also covers clinical staff and makes reference to all of the information required to be obtained as required under Regulation 21, Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

St Stephens Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to St Stephens Surgery

St Stephens is located in Redditch and provides primary medical services to patients living in Redditch with some patients in Studley, Beoley and Alvechurch.

The practice has seven GP Partners (four male and three female), four salaried GPs (one male and three female), a practice manager, an assistant practice manager, five practice nurses, one healthcare assistant, two phlebotomists (a specialised healthcare assistant who collects blood from patients) and reception and administrative staff. There are 10716 patients registered with the practice. The practice is open from 8.00am to 6.30pm Monday to Friday. Patients can access the service for appointments from 8.30am and on line booking is also available. The practice offers extended hours Monday evenings until 8pm and Saturdays 8.30am to 10.30am once a month. The practice treats patients of all ages and provides a range of medical services. St Stephens has a higher percentage of its practice population in the 40 to 45 and 60 to 69 and over age group than the England average.

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

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

The practice provides services for patients with respiratory problems, diabetes and heart disease. It offers child immunisations, influenza and travel vaccinations and maternity and family planning services. The practice also provides a minor surgery and phlebotomy (taking blood) service.

St Stephens does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

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

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

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

Detailed findings

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

How we carried out this inspection

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

We carried out an announced inspection on 13 November 2014. During our inspection we spoke with three GPs, one GP registrar (a GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice), one practice nurse, the practice manager, one phlebotomist, two receptionists and two administrative staff. We spoke with nine patients who used the service about their experiences of the care they received. We reviewed 10 patient comment cards from patients sharing their views and experiences of the practice. We also spoke with a representative from the patient participation group. We also looked at procedures and systems used by the practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred since August 2011. Records were made available to us. Staff told us they were responsible for completing significant event forms, and significant event audits or analysis were carried out each time there was a patient safety incident. Staff told us they were informed of the outcome from these and debriefed. An action plan would be put in place to ensure improvements were made so that the incident did not happen again.

We saw that incident forms and templates were available on the practice intranet and staff had access to them. The practice manager and GPs told us incidents were discussed at regular formal significant event meetings. GPs told us any incidents were also discussed informally by the GPs when they met after surgery each day. We saw meeting minutes which showed that the most recent significant event meeting was held on 10 November 2014. We looked at the practice's summary of significant events for 2013 to 2014. We saw that there was very little detail recorded for each event, but actions points were recorded for all events. We tracked three incidents and saw that the information noted on the forms about the incidents provided very little detail. However, we saw that actions and learning where applicable was recorded for all incidents. For example, we saw that a patient had been issued with all of their medicines twice in a period of seven days. We saw that the practice procedures had been followed, with action taken accordingly.

National patient safety alerts, medical devices alerts and other patient safety alerts were disseminated by email to practice staff. Staff told us they received these by email from the practice manager. The practice manager told us they also ensured a paper copy of the alert was available for all staff in the meeting room. We saw a medical alert folder that was dated 29 August 2014. We saw there were five alerts on the action sheet. This showed the date of the alert, the alert details, action required and who by and the date they had responded to the alert.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible as we saw they were displayed in each consulting and treatment room used by GPs and other clinical staff.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to level three (advanced), and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures through the practice's intranet site or printed copies were available. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. For example, a GP told us about the procedure they had followed recently when they had received information about a child who had been seen by the out of hours GP service. A GP also told us about the procedure they had followed when they had concerns about an older person they had seen.

Good

Are services safe?

Patients' individual records were written and managed in a way that helped to ensure their safety. Records were kept on an electronic system called EMIS, which collated all communications about the patient including scanned copies of communications from hospitals. Staff told us that the system was used to highlight vulnerable patients which ensured staff were alerted to any relevant issues when patients attended appointments. We found that GPs used the required codes on this electronic case management system to ensure risks were clearly flagged and reviewed. We saw that the practice's child protection protocol dated 1 April 2014 clearly stated what codes staff must use on this electronic case management system to highlight vulnerable children.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consulting and treatment rooms. Staff told us that they always asked patients whether they required a chaperone when they received any intimate treatment. Discussion with patients confirmed this. Staff told us that chaperone duties had only been carried out by clinical staff. A GP told us some reception staff had recently been trained as chaperones. However, none had been used to date and their preference of chaperone would be clinical staff. Staff records and discussion with reception staff confirmed this.

Medicines management

We checked medicines stored in the store room and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring refrigerated medicines were kept within the temperature guidelines recommended by the manufacturer. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. However, there were no procedures in place to ensure that non-refrigerated medicines stored in the store room were kept within the temperature guidelines recommended by the manufacturer. The practice manager sent us information three days after the inspection to demonstrate that procedures had been put into place to monitor the temperatures in this room.

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

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

One specialist nurse for diabetes was qualified as an independent prescriber for diabetes medicines only. A GP told us this nurse received regular supervision and support in their role from a named GP.

The practice had a protocol for prescription recording and repeat prescribing which was in line with General Medical Council (GMC) guidance. This protocol was last reviewed on 01 April 2014. This covered how staff generated prescriptions, how changes to patients' repeat medicines were managed and the system for reviewing patients' repeat medicines. A GP told us the practice had made their repeat prescribing procedures more robust following an incident at another practice. The GP showed us the procedures they used to ensure that patients repeat medicines were reviewed and what action was taken if the patient failed to respond to attend a medicine review request. For example, a message from the GP was attached to the prescription. This stated what the patient needed to make an appointment for and who with. Discussion with patients confirmed this. If patients failed to respond, a series of letters were sent to the patient and they were contacted by the GP. A GP told us that any irregular repeat prescription requests outside this protocol were added to the 'day book' by reception staff. These requests were reviewed each day by a GP who then decided what action was taken based on individual patients' requirements. (The 'day book' is a system used by the practice for written communications between reception staff and GPs). Records showed that relevant staff received training on repeat prescription protocols as part of their induction.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that blank computer generated prescription forms and pads were handled in line with the practice's prescription security protocol which was last reviewed on 01 April 2014. These were held securely and tracked through the practice.

Cleanliness and infection control

There were systems in place to keep patients safe from the risk and spread of infection. There was an appropriate

Good

Are services safe?

infection control policy that had last been reviewed on 18 October 2014 available for staff to refer to. We saw that the infection control lead had received appropriate infection control training. Records showed that all staff had received infection control training in 2014. This was confirmed by staff we spoke with.

An infection control audit had been carried out in July 2013. An action plan was in place for the cleaning of privacy curtains as this was highlighted as a shortfall. We saw that this had been actioned as they had been included on the cleaning schedule for the practice. Discussion with staff confirmed this. The practice manager and clinical staff told us a specialist for infection control from the CCG was expected in November 2014 to undertake an infection control audit. Minor surgery was carried out at the practice. We saw that single use instruments were used and they were in date. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

On the day of our inspection all areas seen at the practice were visibly clean and tidy. The majority of patients we spoke with confirmed this. However, one patient was of the opinion that the carpet in reception needed cleaning. The practice manager told us the carpets in reception and the corridors were scheduled for cleaning that coming weekend. Minutes from a practice meeting dated 15 October 2014 stated that cleaning of the carpets had been booked for 15 November 2014. Staff confirmed personal protective equipment and hand sanitising gel was readily available and we saw that it was. We saw that the upholstery on a treatment couch and the arm of the phlebotomist's chair were worn and cracked which exposed the inner padding. We drew the practice manager's attention to this and they immediately ordered a new treatment couch and chair. We also saw that a work surface in one of the treatment rooms and the flooring in the cleaners' cupboard were damaged. We drew the practice manager's attention to this on the day of the inspection. The practice manager sent us information on 18 November 2014 which told us the action they had taken to address these issues. Appropriate action had been taken by the practice manager to address these areas.

The practice had taken reasonable steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections. A legionella risk assessment had been completed dated 27 June 2013 and was due for review on 27 June 2015. There was evidence to support that the schedule of work developed from this risk assessment was actioned. For example, we saw monthly hot and cold water temperature checks were recorded with the last one dated October 2014.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance records and other records that confirmed this. All portable electrical equipment was routinely inspected and records showed recorded checks every three months. We saw evidence of calibration (testing for accuracy) of relevant equipment, for example machines for taking blood pressure. However, we saw three weighing scales in consulting and treatment rooms that had no information on them to show they had been calibrated. We spoke with the practice manager after the inspection who told us they had purchased new weighing scales for these areas.

Staffing and recruitment

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

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

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

The practice had a recruitment policy dated 01 April 2014 that set out the standards it followed when recruiting staff. This did not align with the checks that were being done by the practice prior to the appointment of staff. We saw that the policy did not cover clinical staff and did not make reference to all of the information required to be obtained as required under Regulation 21, Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. For example we saw that monthly internal fire system checks had last been recorded as completed in November 2014. The fire system had been inspected by an external contractor on 09 April 2014. The practice also 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.

Health and safety was a standard agenda at practice meetings. For example, the minutes for the meeting dated 15 October 2014 showed that an action point was to arrange a fire drill at the practice.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews, and followed up if they failed to attend. This was confirmed through discussion with patients who had a long term condition.

We spoke with the lead GP for mental health. They told us they undertook an annual assessment for patients with severe and enduring mental health problems. These patients were called in on a recall system and reviews were also done opportunistically when patients attended for other reasons.

The lead GP for safeguarding children told us that monthly safeguarding meetings were held with the Health Visitor to ensure all clinicians were aware of any problems that might or had occurred. The practice manager told us that notes from these meetings were placed on individual patients' records.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records which showed all relevant staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. However, we saw that the expiry date on the oxygen cylinder was 03 November 2013. The practice manager ordered a replacement immediately. A GP partner and clinical staff told us they would ensure in future that this was checked as part of their weekly checks of the emergency equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest (heart stopping), anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We saw however that there were two packaged airways with an expiry date of November 2011.

Good

Are services safe?

We also saw some airways that were loose and not packaged. The GP removed these immediately and told us they would ensure that the expiry dates of this equipment would be included in the weekly checks completed by designated clinical staff. The practice manager sent us information three days after the inspection to demonstrate that this equipment had been replaced.

A business continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risk areas covered the computer systems, personnel, clinical and the premises. For example, risks identified included power failure, adverse weather, loss of key staff, access to the building and clinical risks such as infection, epidemic and pandemic. The document also contained relevant contact details for staff to refer to. For example, contact details of the electric and gas service suppliers to contact in the event of failure of these services. Copies of this plan were held off site by the management team at the practice.

A fire risk assessment had been undertaken in October 2013 that included actions required to maintain fire safety. For example, a cable reel being used to power the internal phones in the large meeting room. We saw this and all of the other action points had been completed. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment was delivered in line with current legislation and recognised best practice. The GPs confirmed they received information regarding the National Institute for Health and Care Excellence (NICE) guidelines via email and these were used as a point of reference. For example, the GP registrar told us they were doing a presentation about cholesterol following the changes to NICE guidance in July 2014. This was available for all GPs on the practice computer system. GPs told us that any new information was discussed when the GPs met each day after morning surgery and at the monthly practice meetings to which all GPs were invited to attend and contribute. The practice held regular educational meetings where specialist consultants gave talks and had recently started NICE meetings. For example, we saw notes from educational meetings that had been held in the last 12 months about anxiety, diabetes and hip and knee examinations.

Patients with long term conditions received an annual needs assessment. We saw management plans for patients with diabetes and respiratory problems. Staff told us patients were encouraged to be involved with these.

Data from Redditch and Bromsgrove Clinical Commissioning Group (CCG) dated August 2014 showed that the practice were below CCG and national average for the prescribing of antibacterial medicines. This was evidence of good prescribing practice. (CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England).

Patients with a learning disability received an annual health assessment. We saw these were completed using a nationally recognised template. There were systems in place that ensured babies received a new born and eight week development assessment. GPs told us that patients with dementia and mental health difficulties received an annual health review of their physical and mental health, medication and revision of their care plan. Every patient over 75 years had a named GP. Patients we spoke with who had a long term condition told us their care needs were reviewed on a regular basis.

The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational and peer support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

Management, monitoring and improving outcomes for people

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

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included: an audit of patients taking warfarin (a medicine to reduce the clotting of the blood) dated April and October 2014 and a post pregnancy follow up of women with gestational diabetes dated October 2013 and October 2014. (Gestational diabetes happens when you have too much sugar (glucose) in your blood during pregnancy). The outcome of both of these audits showed that learning had arisen from these and changes in practice had been made by GPs. For example, they had written to patients to ensure they attended for a follow up appointment.

The practice had named GP leads for clinics to ensure the smooth running of these and some clinics were run in conjunction with specialised and experienced nursing staff. For example, the practice had three GPs who specialised in diabetes as well as two nurses. Due to this expertise, the practice was able to be involved in insulin initiation as part

of their contract with NHS England. (Insulin helps the body use or store the sugar it gets from food). This enabled patients to be started on insulin without being referred or admitted to the hospital.

GPs at the practice undertook minor surgical procedures in line with their registration and NICE guidance. For example removal of lumps such as cysts. We saw that staff were appropriately trained and carried out clinical audits on their results which were used for learning.

Effective staffing

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

The GPs told us how they had introduced a 'buddy system' each afternoon so that the buddy GP could support the on-call GP as required to accommodate the needs of the service. The practice nurses told us they were able to cover annual leave when colleagues were away. Other staff who worked in the practice were organised into teams, for example reception staff and administration staff. This enabled flexible staffing levels, whereby staff would cover any shortfalls. Staff told us that the practice manager would provide cover as and when required.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We saw that these had been done for 2014. The GP partners told us that their belief was that regular staff reviews acted as a way of reinforcing effective performance, highlighted areas for improvement and recognised developing strengths. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example cervical cytology updates. (Cytology is the examination of tissue cells from the body). Staff told us the practice encouraged staff to undertake courses and also funded the cost of them. Requests were sent to the practice manager for consideration by the GP partners. As the practice was a training practice, doctors who were in training to qualify as GPs were offered adequate appointment times and had access to a senior GP throughout the day for support. Feedback from the trainee we spoke with was positive.

Practice nurses and specialist nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, for the administration of vaccines, cervical cytology and nurse prescribing for diabetes. Those with extended roles such as specialist nurses cared for and reviewed patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease (CHD). They were also able to demonstrate they had appropriate training to fulfil these roles. They were supported by designated clinical lead GPs for each long term condition. Staff told us that the nursing staff held informal monthly meetings to discuss any issues, new protocols and safety information received.

The practice took part in research. The practice had a lead GP for research. Information was available on their website for patients and clearly stated that patients might be asked to take part in research but had the right to decline.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The practice had a system that identified the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP who saw the documents and results was responsible for the action required. Individual GPs were responsible for looking at their own patients' information. If they were away that day, the information would be reviewed by the duty GP. All staff we spoke with understood their roles and felt the system worked well. We were told there were no instances within

Good

Are services effective?

(for example, treatment is effective)

the last year of any results or discharge summaries which were not followed up appropriately. GPs told us urgent referrals were sent the same day and non-urgent within a week of seeing the patient.

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

Information sharing

Training records showed all members of staff had completed training about information governance. This helped to ensure that information at the practice was dealt with safely with regard to patients' rights as to how their information was gathered, used and shared.

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

The practice had not signed up to the electronic Summary Care Record. The practice manager told us this would be up and running in 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information). Meanwhile the practice shared information via fax with the out-of-hours provider about any patient they had concerns about.

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

Consent to care and treatment

We saw that the practice had policies on consent. This included information about the assessment of Gillick competency of children and young adults. (These help clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment). All clinical staff demonstrated a clear understanding of Gillick competencies.

We saw their policy about the Mental Capacity Act 2005 (MCA). (In circumstances where people lack capacity to make some decisions through illness or disability health and care, providers must work within the Code of Practice for the Mental Capacity Act 2005 to ensure that decisions about care and treatment are made in people's best interests). GPs were able to give us examples of how the guidance would be put into practice. Staff we spoke with gave examples of how patients' best interests were taken into account if patients did not have capacity. Clinical staff told us that patients had a choice about whether they wished for a procedure to be carried out or not. For example, the phlebotomist told us how they would talk through the procedure when they were to take blood samples with the patient if they appeared anxious or uncertain. They told us they would discuss any concerns or anxieties they had. We were told that if the patient was unsure and needed more time to consider the procedure this was agreed with them. An appointment was made for them to return to the practice to allow them more time to make their decision.

The practice manager told us they had not been able to access any MCA training locally. However clinical staff had all read the British Medical Association (BMA) guidance. Clinical staff we spoke with understood the key parts of the legislation and were able to describe to us how they implemented it in their practice.

We saw examples of consent forms that had been completed. GPs told us that consent forms were always completed prior to fitting family planning devices such as coils and implants.

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

Good

Are services effective?

(for example, treatment is effective)

Patients with learning disabilities and patients with dementia were supported to make decisions through care plans which they were encouraged to be involved in. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw examples of records that showed care plans were in place and that reviews had been carried out.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a basic health check. This included the completion of a health questionnaire, blood pressure and urine test. Nursing staff told us some new patients might be seen by a GP, this depended on the outcome of the questionnaire information and tests.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included: insulin initiation for patients newly diagnosed with diabetes, warfarin initiation for patients with blood clots, travel advice and vaccinations and family planning. We saw patient self-care was promoted by the practice. For example, there was a blood pressure monitoring machine in place that patients could use to monitor their own blood pressure. We saw there were clear instructions to guide patients on how to operate the equipment. A range of leaflets was available in the reception and waiting room areas.

The practice offered a full range of immunisations for children. The percentage of children receiving the vaccines was in line with the average for the local CCG. The practice offered a full travel vaccination service including yellow fever.

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

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

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

The practice offered structured reviews of all patients with severe and enduring mental health conditions at least once each year. They looked at their physical and mental health, medicines and revision of their agreed care plan. In-house counselling was also available at the practice. Patients with dementia were also offered an annual review.

Antenatal reviews by GPs for pregnant mothers were done at least three times during their pregnancy. Six week post-natal checks and eight week baby checks were also done by an appropriate GP.

Young women were offered a confidential and comprehensive family planning service with one of the female GPs who offered this service. These specific GPs were also able to fit coils and implants as part of the family planning service.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This was the information from the national GP patient survey published July 2014 and a patient survey undertaken by the practice in March 2014 that was completed by 305 patients. The evidence from these sources showed that the majority of patients were overall satisfied with the service offered by the practice. For example, data from the national patient survey showed that 82% of patients would recommend the practice. The practice was well above average for its satisfaction scores on consultations with GPs: 89% of practice respondents confirmed that the GP was good at listening to them, 92% responded that the GP gave them enough time and 97% had confidence and trust in the last GP they saw or spoke to. In the practice survey, 255 patients were overall satisfied with the practice, 33 were neutral and 12 were dissatisfied with the practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 10 completed cards and with the exception of one, they were positive about the service experienced. The majority of patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. The majority said staff treated them with dignity and respect. We spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and the majority said their dignity and privacy was respected. Two patients told us that some reception staff were not always polite.

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

Staff told us they worked to ensure patients' privacy and dignity was respected. Staff told us patients were encouraged to stand back from the reception desk and wait their turn to speak with the receptionist. This made sure that each patient was given the respect and privacy they needed. The practice manager told us that reception staff could take patients to a nearby room if the patient wished to speak with them more privately. None of the patients we spoke with had any concerns about privacy and confidentiality.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff told us they ensured patient's dignity was maintained by making sure the door was locked and that screens were used to enable patients to undress in private. Patients were made comfortable and staff told us they offered a chaperone service if patients preferred. Staff confirmed they had received chaperone training. Staff described their role as a chaperone was to observe safety for the patient and the GP; to observe for any signs of distress, and that they must be in a position to observe the full procedure. We saw that information about chaperones was made available to patients in the reception/waiting room and in consulting and treatment rooms. Patients we spoke with were aware of this facility.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that they felt fully informed and involved in the decisions about the care. They told us they felt listened to and supported by clinical staff and were given sufficient time during consultations to discuss any concerns. Patient feedback on the comment cards we received were, with the exception of one, also positive and supported these views. One patient raised a concern about a consultation with a GP over the last year, however they then commented on how supportive the nurses had been at the practice.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 78% of practice respondents said the GP was good at involving them in care decisions and 86% felt the GP was good at explaining treatment and results; 72% of practice respondents said the nurse was good at involving them in care decisions and 81% felt the nurse was good at explaining treatment and results. These results

Good

Are services caring?

were all above the regional average. Results from the practice's own satisfaction survey showed that 88% of patients said they would recommend the practice to family and friends.

Staff told us that translation services were available for patients who did not have English as a first language. The check-in facilities at the practice were automated and multilingual. Staff told us that one of the current GP registrars who worked at the practice spoke Polish and a GP spoke Urdu.

The practice manager told us they had not been able to access any Mental Capacity Act (MCA) training locally. However clinical staff had all read the British Medical Association (BMA) guidance. Clinical staff we spoke with understood the key parts of the legislation and were able to describe to us how they implemented it in their practice. (In circumstances where people lack capacity to make some decisions through illness or disability health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 to ensure that decisions about care and treatment are made in people's best interests). Staff were provided with protected time to undertake all training. Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us the patient always came first and was involved in decision making. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multi-Disciplinary Team (MDT) approach with district nurses, palliative care nurse and hospitals. We saw that the Gold Standard Framework (GSF) palliative care meetings were held monthly. Staff told us minutes from these meetings were not recorded. However, information that related to individual patients were recorded on their medical records. The GSF is a practice based system to improve the quality of palliative care in the community so that patients receive supportive and dignified end of life care, where they choose.

Patient/carer support to cope emotionally with care and treatment

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

The practice had an active patient participation group (PPG) to help them to engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. We spoke with a representative of the PPG who explained their role and how they worked with the practice. They told us that the group was mainly retired people and that more patients needed to be encouraged to join to gain views from different age groups. The representative told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes in the health economy to them and listened to any concerns they had. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patient surveys. For example, the outcome of the 2012/2013 survey showed that more appointments with female GPs had been made available as the practice had employed two more female GPs. The practice telephone number had been changed from a 0844 to a local dial code number. Online appointment booking was made available through a new computer system called EMIS Web.

The practice had a very low turnover of staff which enabled a good continuity of care. Some staff had been at the practice for over 25 years. The practice ran a GP triage system for patients who could not wait for the next available appointment, or had conditions that were of a more urgent nature. For example, people with multiple and complex long term conditions. GPs told us that only the triage GP could book longer appointments with patients. Appointments could be made with a named GP or nurse. All older people had a named GP who had overall responsibility for their care. This included the review of their conditions that might involve a home visit to see these patients. A GP told us all home visit requests were triaged by a GP.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us that usually the patient was accompanied by a family member or friend who would translate for them. Staff told us they would arrange for access to a telephone interpreter if required and that information could also be translated via the website. We were told that a GP spoke Urdu and one of the current GP registrars spoke Polish.

Staff told us that no homeless patients were currently registered with the practice. Staff told us however that should a homeless person need to register as a patient at the practice, this would be done so they could receive treatment. Staff told us that no one would be turned away from the practice.

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

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a hearing loop system

Good

Are services responsive to people's needs?

(for example, to feedback?)

available for patients with a hearing impairment for use in reception and a portable system that could be used in the consulting rooms. There was clear signage informing patients where to go. There was a disabled toilet and wheelchair access to and throughout the practice for patients with mobility difficulties. All consulting and treatment rooms were on the ground floor of the building. To access other areas that might be used by patients or staff with a mobility disability, there was a shaft lift suitable for wheelchair users. We saw there was a door bell at the front door at a suitable height to enable patients with mobility difficulties to request assistance from staff as needed. There were two disabled parking spaces at the front entrance of the practice. We saw that reception staff were aware of patients waiting for their consultation who had a mobility difficulty. For example, the receptionist left their post and came through to reception to assist a patient through the double doors to the consulting rooms as soon as they were called.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable people who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it.

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

The practice accepted any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met. All staff had undertaken equality and diversity training in 2014. Staff we spoke with confirmed this.

Access to the service

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

The practice opened from Monday to Friday from 8.00am to 6.30pm each week. All clinics were available by appointment and patients could book these by telephone, online or at the reception desk at the practice. A nurse was available at all times Monday to Friday between 8.30am until 6pm and until 8pm on a Monday. The practice offered extended hours Monday evenings until 8pm and Saturdays 8.30am to 10.30am once a month for those patients who were unable to attend appointments during the normal working day. Longer appointment times were made available to patients as needed, such as patients with poor mental health, learning disability and mental health reviews and for patients with long term conditions. Minutes from a reception staff meeting dated 20 March 2014 showed that patient requests for longer appointments had to be authorised by a GP. Overall patients we spoke with were happy with the service provided. The majority of patients told us they could access same day appointments if the need arose.

The practice was able to monitor the appointment system to make sure the needs of patients were being met. Data from the NHS patients survey dated July 2014 showed that the proportion of respondents to the patient survey who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment was better than national average. The practice had also introduced a 'daily express' clinic to a GPs list each day which provided extra telephone appointments and short five minute appointments that could be used by the GP.

The practice was accessible to patients. We saw that reception and waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. We saw that a shaft lift was available for patients to access the upper floors of the practice building should the need arise. All consulting and treatment rooms were on the ground floor of the building. Accessible toilet facilities were

Good

Are services responsive to people's needs?

(for example, to feedback?)

available for all patients attending the practice including baby changing facilities. Information leaflets for health promotion were available for patients to take away with them should they wish to do so.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures dated 1 April 2014 were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person and a lead GP for complaints who handled all complaints in the practice. We looked at the complaints log for the last twelve months and found that these were satisfactorily handled and dealt with in a timely way.

The practice reviewed complaints on an annual basis to detect themes or trends. This was discussed and reviewed by the GPs at their annual away day meeting We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

The GPs and the practice manager told us that complaints were discussed at the practice meetings. We saw that reception staff had received feedback from some complaints through discussion and customer service training. Other staff we spoke with were not aware of any feedback from complaints or any action plans. We saw minutes of meetings with clinical and non-clinical staff. However, it was not clear if complaint feedback had been discussed. We saw that meeting minutes were brief and did not provide an overview of the content of the information discussed for each agenda item in addition to any action points. This would ensure that the content and actions from meetings could be cascaded more effectively to the staff team. Staff told us they were aware of what action they should take if a patient complained.

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

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

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and values were set out in a practice document. The practice's patient charter was available on their website. The practice's aim was to provide the highest standards of medical care within the resources available to the practice.

The practice placed high values on communication with their patients as they felt this would help patients to understand their present problems and improve their outcomes for long term health. The practice manager told us the strategy for each coming year was discussed with staff at their annual away day and during individual staff appraisals. We spoke with 11 members of staff and they were all familiar with the values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer within the practice and reception and nursing staff had printed copies in their respective team files. We looked at 13 of these policies and procedures. All 13 policies and procedures we looked at had been reviewed annually and were up to date. The practice had started to use text messaging as a form of communication with patients to remind them about appointments or for health promotion. We saw there was no policy in place for this. The practice manager responded immediately and sent us a copy of this new policy dated 17 November 2014, three days after the inspection.

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

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included; an audit of patients taking warfarin (a medicine to reduce the clotting of the blood) dated April and October 2014 and a post pregnancy follow up of women with gestational diabetes dated October 2013 and October 2014. (Gestational diabetes happens when you have too much sugar (glucose) in your blood during pregnancy). The outcome of both of these audits showed that learning from these and changes in practice by GPs. For example, they had written to patients to ensure they attended for a follow up appointment.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as spillages. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Staff showed us risk assessments that had been completed for risks identified such as needle stick injuries.

Leadership, openness and transparency

There was a clear and visible leadership and management structure in place. For example one of the GP partners was the lead for safeguarding, and another the mental health lead. We spoke with staff from different teams and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible. There was evidence of strong team working and support for each other. Records showed that regular meetings took place for all staff groups. The practice manager told us that they met with the GPs each month and information from these meetings was shared with staff. Staff told us that the GPs, practice manager and team leaders were very supportive.

Staff told us that there was a positive culture and focus on quality at the practice. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. We spoke with a GP who confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

Are services well-led?

Good

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

We saw from minutes that a range of meetings were held monthly, quarterly and annually. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at the meetings.

One of the GP partners described the ethos of the practice in their presentation to us. They told us they looked after each other both in a practical and holistic way. They all knocked on each other's doors for advice, checked on GP's surgeries to lend a hand if running late or struggling with the volume on the 'on call'. They also supported each other with any personal and health issues. This was confirmed through discussion with staff.

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

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

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

The practice had an active patient participation group (PPG) to help them to engage with a cross section of the practice population and obtain patient views. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. We spoke with a representative of the PPG who explained their role and how they worked with the practice. They told us that the group was mainly retired people and that more patients needed to be encouraged to join to gain views from different age groups. The practice manager told us they were trying to recruit new members. The representative told us the PPG had a good working relationship with the practice, and felt that the GPs explained any changes in the health economy to them and listened to any concerns they had.

The practice had gathered feedback from patients through patient surveys and complaints received. We saw that the practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patient surveys. For example, the outcome of the 2012/2013 survey showed that more appointments with female GPs had been made available as the practice had employed two more female GPs. The practice telephone number had been changed from a 0844 to a local dial code number. Online appointment booking was made available through a new computer system called EMIS Web.

Minutes from a meeting with the PPG in January 2014 showed they discussed ideas for the patient questionnaire for 2014. The following areas were viewed as a priority: waiting times; telephone systems; patients not attending booked appointments; access to appointments; telephone appointments; online prescriptions and booking appointments and the use of text reminders. A representative for the PPG told us this was a proactive practice. They told us the practice staff and PPG members had discussed the outcome of the survey dated March 2014 and produced an action plan. We saw this was published on the practice website. This action plan showed that the current priorities for 2014/2015 were: supporting patients to access appointments including online; providing treatment for minor illnesses by nursing staff; promoting text messaging to remind patients about appointments to reduce the number of non-attenders and the refurbishment of the reception area.

The practice reviewed complaints on an annual basis to detect themes or trends. This was discussed and reviewed by the GPs at their annual away day meeting We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. We saw that 10 comments had been made on the NHS Choices website for 2014. These contained a mix of positive feedback and some less positive feedback. The practice manager told us they intended to respond to these shortly now that they had managed to regain their pass worded access to be able to do this.

Are services well-led?

Good

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

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

Management lead through learning and improvement

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

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

The practice was committed to becoming a progressive learning environment. Teaching and training was a core part of their work. The practice had been training GP registrars since 2005. The practice also provided placements for medical students for Birmingham and Warwick Medical Schools.

We looked at the practices summary of significant events for 2013 to 2014. We saw that there was very little detail recorded for each event, but actions points were recorded for all events. We tracked three incidents and saw that the information noted on the forms about the incidents provided very little detail. However, we saw that actions and learning where applicable was recorded for all incidents. For example, we saw that a patient had been issued with all of their medicines twice in a period of seven days. We saw that the practice procedures had been followed, with action taken accordingly.