Radbrook Green Surgery

Quality Report

Radbrook Green 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
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 6 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this practice is outstanding. We found the practice to be outstanding in the caring and responsive domains and good in the safe, effective and well led domains. We found the practice provided outstanding care to older people, people with long term conditions and people whose circumstances may make them vulnerable. They provided good care to families, children and young people, working age people 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. Systems were in place to monitor and make required improvements to the practice.
- Patients were very satisfied with how they were treated and this was with compassion, dignity and respect. GPs were good at listening to patients and gave them enough time.
- Not all patients found it easy to get through on the telephone to book an appointment however, most patients reported they got an appointment when needed.

We saw several areas of outstanding practice including:

- The practice used a nationally recognised patient safety framework to enable them to identify and put plans of care in place for patients with the highest health risks.

Summary of findings

- The practice employed a community and care co-ordinator to provide services to support vulnerable people. This included a support group for carers of people with dementia and a twice monthly bereavement support group.
- The practice ran a support group for patients with chronic fatigue and Myalgic Encephalopathy (ME) to ensure patients were supported in decisions about available care and treatment.
- The practice had proactively engaged with teenagers to involve them in health care services.
- The practice had helped to established Compassionate Communities, a voluntary service that the community and care co-ordinator worked alongside to provide support for patients whose circumstances may make them vulnerable.
- The practice provided GP support to a 12 bedded rehabilitation unit in one of the nursing homes for patients whose vulnerability meant they needed additional support following discharge from hospital. The aim of this was to reduce hospital re-admission rates.

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

The provider should:

- Ensure that all patient group directions for the safe delivery of childhood immunisations are in date.
- Introduce a system for monitoring GP prescription pads, in line with national guidelines.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 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. All staff had received an appraisal and personal development plans were in place for staff. Staff worked with multidisciplinary teams.

Are services caring?

Outstanding

The practice is rated as outstanding for caring. Data showed patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently positive. We observed a patient centred culture and saw that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. The practice

Summary of findings

reviewed the needs of its local population and engaged with the NHS England's Local Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. 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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active PPG. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding

The practice is rated as outstanding for the care of older people. Examples of outstanding practice were that GPs from the practice carried out weekly ward rounds in two of the care homes where they provided care to older people. This enabled them to identify risks to older patients who had a deterioration in their health.

The practice also provided GP support to a 12 bedded rehabilitation unit in one of the nursing homes for older patients whose vulnerability meant they needed additional support following discharge from hospital.

For further information please refer to the 'outstanding practice' and 'detailed findings' sections of our report.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions. Examples of outstanding practice were that the practice had implemented an in-house support group for patients with chronic fatigue such as Myalgic Encephalopathy (ME). They had also started to extend their care to include a support group for younger, lonely patients and some patients with long term conditions such as Multiple Sclerosis and Huntington's Chorea.

The practice contracted in specialists in diabetes and respiratory medicine to provide specialist assessment and education of patients with long term conditions. One of the practices' nurses also worked as a community respiratory nurse for the local CCG. They used their additional skills to run the asthma and chronic obstructive pulmonary disease (COPD) clinics with supervision from a local respiratory consultant.

For further information please refer to the 'outstanding practice' and 'detailed findings' sections of our report.

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. There were systems in place to engage with teenagers and plans to provide a support group for lonely, young people. Immunisation rates were high for all standard childhood immunisations. We saw

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.

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. 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

Outstanding

The practice is rated as outstanding for the care of people living in vulnerable circumstances. An example of outstanding practice was the practice had implemented a bereavement support group at the practice for their patients. To address the social isolation carers may experience, the practice had also employed a community and care co-ordinator who ran an in-house dementia care group to support carers of people with dementia.

The practice worked closely with the local learning disabilities facilitator to help the practice to co-ordinate their learning disabilities register and to support these patients to attend health assessment reviews. The practice worked closely with Shrewsbury Ark, a charity for homeless people, in contacting patients and arranging follow up health assessments.

For further information please refer to the 'outstanding practice' and 'detailed findings' sections of our report.

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). Most people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including Shropshire Independent Advocacy Service and Improving Access to Physiological Therapies. The practice had

Summary of findings

its own counsellor who worked closely with other mental health services in Shrewsbury to support patients with complex acute mental health issues. Staff had received training on how to care for people with mental health needs.

Summary of findings

What people who use the service say

All of the 12 patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the 15 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were positive. Patients told us the staff were always helpful, professional, caring and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Some patients told us they experienced problems getting through to the practice on the telephone to make an appointment. Most patients however told us the appointment system was easy to use and met their needs.

The results from the National Patient Survey showed that 92% of patients said that their overall experience of the practice was good or very good and that 85% of patients would recommend the practice to someone new to the area.

Areas for improvement

Action the service SHOULD take to improve

The provider should ensure that all patient group directions for the safe delivery of childhood immunisations are in date.

The provider should introduce a system for monitoring GP prescription pads, in line with national guidelines.

Outstanding practice

The practice used a nationally recognised patient safety framework to enable them to identify patients with the highest health risks. When a patient was identified as being of high risk, the practice used their significant events meetings to put plans of care in place.

The practice employed a community and care co-ordinator to provide services to support vulnerable people. This included a support group for carers of people with dementia and a twice monthly bereavement support group.

The practice ran a support group for patients with chronic fatigue including Myalgic Encephalopathy (ME) to ensure patients were supported in decisions about available care and treatment.

The practice had proactively engaged with teenagers to involve them in health care services. The community and care co-ordinator was extending their work to include a support group for younger, lonely patients and some patients with long term conditions such as Multiple Sclerosis and Huntington's Chorea.

The practice had helped to establish Compassionate Communities (Co Co). Co Co is a voluntary service that the community and care co-ordinator worked alongside to provide support for patients whose circumstances may make them vulnerable. Its aim was to reduce loneliness and social isolation. Medical students from the practice used their community project to start the recruitment of volunteers who helped to visit patients.

The practice provided GP support to a 12 bedded rehabilitation unit in one of the nursing homes for patients whose vulnerability meant they needed additional support following discharge from hospital. The aim of this was to reduce re-admission rates to hospital.

Radbrook Green Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor and a practice manager specialist advisor.

Background to Radbrook Green Surgery

Radbrook Green Surgery is a purpose built primary care medical centre. It was built in 1989 to serve the local population by providing general practitioner services. The premises are owned by the partners. The building has benefitted from subsequent extensions and refurbishments improving space, access, infection control and facilities. It is situated opposite a small shopping centre serving local residents and location benefits include public transport links and parking facilities.

A team of five GP partners, two salaried GPs, four nurses including an advanced nurse practitioner, three health care assistants, a practice manager, nine receptionists and 11 administrative staff provide care and treatment for approximately 9,100 patients. There are four female and three male doctors at the practice to provide patients with a choice of who to see. The practice provides an anticoagulation clinic for patients who are on warfarin and need to have their blood monitored on a regular basis. The practice has been a training practice for doctors to gain experience and higher qualifications in General Practice and family medicine since 1960. They do not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

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

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

How we carried out this inspection

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:

Detailed findings

- 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)

Before carrying out our inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a spokesperson from the Patient Participation Group (PPG) and managers of three care homes where Radbrook Green Surgery provided care and treatment. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive.

We carried out an announced visit on 6 November 2014. During our inspection we spoke with three GPs, one nurse, three receptionists, the practice manager, three administrative staff and 12 patients. We observed how patients were cared for. We reviewed 15 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, one member of staff told us how they had responded when a patient collapsed at the surgery. They told us they had reported and recorded the event and were invited to the practice's bi-monthly significant event meeting. The member of staff described the learning from this event and how future procedures in handling this type of situation had been changed. They confirmed that the information was shared with all staff.

We reviewed safety records and incident reports and minutes of meetings where these were discussed over the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

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 during the last year and these were made available to us. Bi-monthly significant events meetings were held by at least two of the GPs and staff were invited to attend these to discuss and learn from significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to ensure these were managed and monitored. We tracked two significant events and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, following a patient being on a particular medicine too long, systems had been changed to prevent this from happening again.

National patient safety alerts such as alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were disseminated by the senior GP partner to all practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at staff meetings to ensure all were aware of any relevant to the practice and where action needed to be taken. For example, they told us how they had used an alert regarding the use of non-steroidal anti-inflammatory drugs (NSAIDs) to audit and make changes to the treatment patients received. We saw two completed audit cycles that demonstrated that the audit had been carried out and improvements to patient health outcomes had been made.

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 not always easily accessible however or clearly on display.

The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. The safeguarding lead had received the higher level three safeguarding training to fulfil this role. We saw certificates confirming this. Most staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern. The staff who were not aware of who the safeguarding lead was told us they would inform the practice manager if they had any concerns.

A chaperone policy was in place and visible in the waiting room and in consulting rooms. Chaperone training had been undertaken by all nursing staff. If nursing staff were not available to act as a chaperone some receptionists had also undertaken training. Staff we spoke with understood their responsibilities when acting as chaperones including where to stand to observe the examination and what to do

if they had any concerns regarding the examination. Safeguarding checks had been completed for all clinical staff and administrative staff who carried out chaperoning duties.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, EMIS web, which collated all communications about the patient including scanned copies of communications from hospitals and results from tests and X-rays.

There was a system to highlight vulnerable adults and children on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans or patients with learning disabilities. There was a system in place that highlighted patients with caring responsibilities and the patients they cared for. This enabled the practice to involve carers in the care and treatment decisions for the person they cared for. We saw that there were 252 carers registered with the practice.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Practice staff were aware of the action to take if the fridge temperature range was not maintained.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw that medicines used in the practice were in date. There was also a system in place for checking the medicines GPs carried in their doctor's bag when carrying out home visits.

The practice participated in the Prescribing Quality and Optimisation Scheme. We saw that there were systems in place to review prescribing in nursing homes; repeat prescribing; and monitoring of prescribing for cardiovascular, endocrine and pain indicators. For example, a waste audit with a focus on oral nutritional supplements was to be carried out. We saw that the practice was aware of where their prescribing rates were high and where they needed to be decreased.

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 for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up to date copies of most of the vaccines delivered by nurses however the PGDs for two childhood vaccinations were out of date. One had expired in March 2014 and the other in March 2012. The practice manager told us they were aware of this and that they had been having problems getting updated PGDs from the local Clinical Commissioning Group (CCG). We saw that nursing staff had received the appropriate training in immunisation to support the safe administration of these vaccines.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient.

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead for infection control and an infection control policy for staff to refer to. We saw evidence that infection control audits had been carried out and that any improvements identified for action were completed on time. Issues identified were discussed at staff meetings and a member of the nursing team described to us recent changes that had taken place to address issues identified. An example of this was the introduction of specialised sharps boxes to dispose of medicines that may be hazardous to health.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was a policy for needle stick injuries and staff

knew what to do if this occurred. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice had 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 in July 2014 to protect patients and staff from harm.

Equipment

Patients were protected from unsafe or unsuitable equipment. Emergency equipment such as a defibrillator (an electronic device that applies an electric shock to restore the rhythm of an irregular heart) was available for use in a medical emergency. We saw that the equipment was checked monthly to ensure it was in working order and fit for purpose. 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 logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as weighing scales.

Staffing & Recruitment

Patients were cared for by suitably qualified and trained staff. We saw evidence that health professionals, such as doctors and nurses, were registered with their appropriate professional body and so considered fit to practice. There was a system in place to monitor health professionals' registrations were in date. There was a recruitment policy in place but it did not identify the need to explain gaps in employment history or the need for satisfactory evidence of conduct in previous employment. The practice manager updated the policy to include these requirements and forwarded a copy to us the day after our inspection. We looked at the records of three members of staff and saw that recruitment processes and checks had been carried out but there was no evidence of satisfactory conduct in previous employment. The practice manager explained that two of the members of staff had previously been employed by the practice and the third had been recruited by an external agency. Within one working day the practice manager forwarded risk assessments to us for all three members of staff explaining why the decision was taken not to take up references and how they would safely manage the risk.

The practice were unable to show us risk assessments for administrative staff who had not had safeguarding checks carried out. This was because the risk assessments had been lost during a recent computer virus attack on the practice's computer system. Through discussion with the practice manager however, it was clear that they had a clear rationale why these staff did not require safeguarding checks to carry out their role.

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 was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

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

Monitoring Safety & 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. A premises audit had been completed in October 2014 to reduce the risk of harm to patients and staff. The practice also had a health and safety policy and had completed Control of Substances Hazardous to Health (COSHH) risk assessments.

Staffing establishments were reviewed to keep patients safe and meet their needs. Where staffing issues had been identified, we saw that action plans were in place outlining how risks would be managed and work re-allocated. We saw that risks were assessed, rated and mitigating actions recorded to reduce and manage the risk.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health

and well-being. The practice used a nationally recognised patient safety framework to enable them to identify patients at risk. We saw that the framework enabled staff to identify patients who had attended for three or more consultations in seven days; received a new significant diagnosis; had attended the out of hours service or been admitted to hospital as an emergency. Patients were given a risk rating and if significantly high they were discussed at the significant event meeting to identify ways of managing their risk. We were shown an example of a patient intervention following a review at the meeting and how procedures and protocols had been changed to improve care.

GPs carried out weekly ward rounds in two of the care homes they provided care for. This enabled them to identify risks to older patients who had a deterioration in health. Staff at the care homes told us that the GPs always responded quickly to any requests for an urgent visit. There were emergency processes in place for identifying acutely ill children and young people and children were provided with on the day appointments when needed. For patients with long term conditions there were emergency processes in place. For example, one of the practice's nurses also worked as a community respiratory nurse for the local CCG. They used their additional skills to run the asthma and chronic obstructive pulmonary disease (COPD) clinics with supervision from a local respiratory consultant. Any patient with an increased risk to their health due to asthma or COPD could be seen quickly by the respiratory team. The practice worked closely with the Shropshire Independent Advocacy Service (SIAS) to assist and respond to risks for patients with social and mental health issues. One GP described to us how they had responded to a patient experiencing a mental health crisis by referring them for emergency care and treatment through the local mental health crisis team.

Arrangements to deal with emergencies and major incidents

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

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, anaphylactic shock and low blood sugar. Processes were also in place to check emergency medicines were within their expiry date and suitable for use and we saw that they were.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of domestic services, flood, staff shortages and IT failure. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system. The practice had recently installed a new clinical computer system to bring it into line with other local practices in the area. A computer virus had entered the computer system resulting in a loss of much of the practices information. We saw evidence that the supplier of the new computer system had admitted they had failed to back up the information held on the computer resulting in a major loss of information. Patients' notes were able to be recovered however the practice had had to implement their business continuity plan to manage other areas such as the loss of governance and financial documents. We saw that the business continuity plan had been effective with no disruption to patient care.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. The practice had a Health and Safety policy that included fire prevention and safety and this was covered during new staff inductions. Staff we spoke with clearly described their roles and responsibilities in keeping patients safe in the event of a fire.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes that demonstrated that new guidelines were reviewed at monthly clinical meetings. The practice also worked with the GP Registrars and medical students to ensure they were aware of the importance of NICE guidelines. For example, we saw an example of a tutorial presented to trainees in April 2014 by one of the GPs regarding NICE guidelines relating to acute kidney injury. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. Although we found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, the practice did not have a systematic way of checking that NICE guidelines had been implemented.

The GPs told us they led in specialist clinical areas such as diabetes and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened. One of the practice nurses at the practice also worked as a community respiratory nurse for the local hospital. Under supervision of a local respiratory consultant from a nearby hospital, this provided the nurse with the specialist knowledge they needed to monitor and improve health outcomes for patients with asthma and chronic obstructive pulmonary disease (COPD).

The senior GP partner showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was lower than the CCG average. This demonstrated that the practice was proactive in monitoring the prescribing of antibiotics. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital and patients receiving palliative care. We saw minutes from monthly multi-disciplinary meetings confirming that the practice followed the gold standard framework for end of life care. We saw that multi-disciplinary working between the practice, district and palliative care nurses took place to support these vulnerable patients. We saw there was a system in place that identified patients at the end of their life. This included a palliative care register of eight patients and alerts within the clinical computer system making clinical staff aware of their additional needs.

Regional CCG data showed that the practice was in line with referral rates to secondary and other community care services for most conditions. A GP showed us the system they had in place for identifying areas of high referral. We saw that there was a higher than average dermatology referral rate. We saw that the practice had identified this and introduced peer review of dermatology referrals to ensure they were appropriate. All GPs we spoke with used national standards for the referral of patients, for example patients with suspected cancers to ensure they were seen within two weeks. The practice used the Referral Assessment Service (RAS) to refer patients to other services through choose and book (a system that enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) and we saw an example when this had been carried out. We saw that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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 race was not taken into account in this decision-making.

By reviewing the needs of their patients, the practice had identified several areas where there were gaps in the provision of health care services. To address some of the gaps, the practice employed a community and care co-ordinator (C&CC). As part of their role, C&CC ran and co-ordinated a support group for carers of people with dementia, a support group for patients with chronic fatigue such as Myalgic Encephalopathy (ME) and a bereavement support group.

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

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

The practice showed us three clinical audits that had been undertaken in the last two years. All of these were completed audit cycles where the practice was able to demonstrate that the changes made, following the analysis of the data collections and changes introduced, had improved health outcomes for patients. An example of this was the prescribing of Clopidogrel, a medicine that inhibits blood clots. We saw that an audit had been completed which identified issues around recording the appropriate duration the medicine was to be prescribed for. We saw that changes were made to the way the prescription instructions were written and recorded to ensure patients received the medicine in line with national guidelines and the advice of their hospital Consultant. Following a second audit, the recording of the duration the medicine was to be prescribed for had increased from 40% to 77%. Where the duration had not been recorded, it was because the patient required long term treatment rather than for a specific period. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. An example of this was following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) the practice had completed two clinical audits for patients prescribed non-steroidal anti-inflammatory drugs (NSAIDs).NSAIDs are medicines used to treat conditions such as pain or inflammation. Following changes made from the first audit, the second audit demonstrated that all patients received the appropriate treatment which was reviewed regularly.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This was reviewed at quarterly QOF meetings. For example, 100% of patients with learning disabilities had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma and COPD. This practice was not an outlier for any QOF (or other national) clinical targets.

The team were making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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 practice also participated in local benchmarking run by the 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 such areas as antibiotic prescribing and hospital referral rates.

Effective staffing

Practice staff included medical, nursing, managerial, community support, cleaning and administrative staff. We reviewed staff training records and saw that all staff were up to date or in the process of attending essential training such as annual basic life support training. We noted a good skill mix among the doctors with two GPs having additional diplomas from the Faculty of Sexual and Reproductive Healthcare which was revalidated three yearly. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

Are services effective?

(for example, treatment is effective)

We were shown evidence that staff in all roles were provided with a thorough induction process. We saw that staff had access to a range of training opportunities. We looked at records which showed that all staff training was up to date or in the process of being completed.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. There was a system in place for staff groups to receive team appraisals for two years then an individual appraisal the third year. Staff told us they preferred this style of appraisal because it helped to resolve any issues between staff, identified team and personal objectives and improved team building. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. An example of this was one practice nurse told us how they had been supported and funded to complete a degree in advanced nursing practice.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines and cervical cytology. Those with extended roles, for example those staff seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The IT department consisted of a team of three staff who were responsible for scanning hospital letters and the summarising of records. We spoke with two members of this team who demonstrated a clear knowledge of their role and responsibilities in ensuring that the information received was processed and forwarded to the appropriate GP in a timely manner. The GP who saw these documents and results was responsible for the action required.

The practice held monthly multidisciplinary team meetings to discuss the needs of patients with complex health needs such as terminally ill patients. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Minutes from multi-disciplinary meetings between the practice, palliative care nurses and district nurses demonstrated that patients who were receiving end of life care were provided with appropriately co-ordinated care. We saw that the practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed.

We saw that the practice worked closely with other services in the region to ensure that the care they provided to patients was effective. The practice also engaged with the local GP federation of 44 practices to look at GP practice effectiveness in meeting the needs of patients. The GPs worked with a local nursing home to provide a rehabilitation service. This included 12 step down beds for older patients whose vulnerability meant they needed additional support following discharge from hospital. We spoke with the manager from this nursing home who told us that the system was effective in meeting patients' needs.

The practice had introduced several innovative ways of working with other services to deliver effective support to their patients with long term conditions. This included working with an external nutritionist nurse who attended group clinics held at the practice for patients with diabetes. They also used the specialist knowledge of the practice nurse who was also a community respiratory nurse to support patients with asthma and COPD. A hospital respiratory consultant also provided support at respiratory clinics held at the practice. The practice had proactively visited local schools to engage with teenagers to promote services available for them at the practice such as sexual health. Teenagers did not need to be a patient at the practice to receive this service. There was a system in place to inform Health Visitors when a child under five years of age had registered with the practice. This enabled children and their families to receive the appropriate care and support that the Health Visiting service provided.

We saw that the practice had worked closely with the local learning disabilities facilitator to help the practice to co-ordinate their learning disabilities register and to support these patients to attend health assessment reviews. The practice worked closely with Shrewsbury Ark, a charity for homeless people, in contacting patients and arranging follow up health assessments. They also worked

Are services effective?

(for example, treatment is effective)

with Shropshire Independent Advocacy Service (SIAS) to assist patients experiencing poor mental health in accessing health care services. The GPs and practice's counsellor worked closely with the service, Improving Access to Physiological Therapies (IAPT) and the local Community Mental Health Team (CMHT) to meet the needs of patients with complex acute mental health issues.

Information sharing

The practice used several electronic systems to communicate with other services. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making patient referrals to other services. The practice used the Choose and Book system to do this. Choose and Book enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

The practice had systems to provide staff with the information they needed. Staff used the EMIS web electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system and the practice had commissioned additional support from an external IT specialist within the area to support staff. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. We saw that staff had received training in the MCA through the practice's on-line training package. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions and were involved in developing their own individual care plans. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competency when obtaining consent from children and young people. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

There was a practice policy for documenting consent for specific interventions. An example of this was that for all minor surgical procedures, a patient's verbal consent was documented in their electronic notes with a record of the relevant risks, benefits and complications of the procedure. When young people experienced repeat urine infections, there was also a consent form for them to sign if they agreed to the additional screening for Chlamydia.

Health promotion and prevention

It was not practice policy to routinely offer new patient health checks to all new patients who registered with the practice. However, there was a policy in place to enable staff to identify new patients' needs. This included a patient registration form which included sections where patients could alert the practice to any specific needs they may have. This was overseen by the reception manager and if a need was identified the patient was called in for a new patient check. We saw that a welcome letter was also sent to new patients providing information about access to the practice and repeat prescriptions. If a new patient was between the ages of 40-75 years of age they were routinely invited to attend for a NHS health check. NHS health checks were offered to all the practices' patients aged 40-75 years of age. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic Chlamydia screening to patients aged 18-35 and offering smoking cessation advice to smokers.

Through analysis of data held on the practice's computer system, the practice had identified groups of patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 28 out of 28 had received an annual physical health check. The practice had also identified the smoking status of patients over the age

Are services effective?

(for example, treatment is effective)

of 16 and actively offered nurse-led smoking cessation clinics to these patients. Evidence of evaluation of the effectiveness of this service was not available on the day of our inspection. The nursing staff also ran a one year programme called Help 2 Slim to support patients to lose weight. Weekly and fortnightly consultations were provided and the practice nurse gave an example of how patient's confidence had increased when they started to lose weight. The effectiveness of this programme was monitored by the CCG but was not available on the day of our inspection. Other health promotion and prevention services offered by the practice included family planning services including free condoms and Chlamydia screening for young people; a menopause service; continence advise and affiliation with Cycle Shrewsbury who ran cycle events from the practice to improve patient fitness.

To help elderly and vulnerable patients to remain in their own home, to reduce loneliness and social isolation and so increase their wellbeing, the C&CC linked with Compassionate Communities (Co Co). Co Co was a voluntary service made up of a team of volunteers who offered one-to-one support for patients in their own homes by providing practical help or a befriending service. The C&CC was extending their work to include younger lonely people and some patients with long term conditions such as Multiple Sclerosis and Huntington's Chorea.

The practice offered a full range of immunisations for children, travel vaccines including Yellow fever and influenza vaccinations in line with current national guidance. Last year's performance for childhood immunisations was above average for the CCG.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of over 400 patients undertaken by the practice's Patient Participation Group (PPG) between September and November 2013. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that 92% of respondents said that their overall experience was good or very good and 85% of respondents would recommend the surgery. These results were above the regional Clinical Commissioning Group (CCG) average. The PPG survey supported these findings with satisfaction levels of 95% and 90% respectively. The practice was also above the CCG regional average for its satisfaction scores on consultations with doctors and nurses with 95% of practice respondents saying the GP was good at listening to them and 95% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 15 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were always helpful, professional and caring. They said staff treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Four patients told us they experienced problems getting through to the practice on the telephone to make an appointment. This was supported by the national GP survey with 64% of respondents finding it easy to get through to the practice by telephone. This was below the CCG regional average but the practice had implemented an action plan to try to address this issue.

We spoke with 12 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. There was a ticket system in place to speak with the receptionist which ensured there was only one patient at the reception desk at any time. This avoided patient queues at the reception desk and prevented patients from overhearing potentially private conversations. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice or reception manager. The reception manager and the practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Reception staff described to us how they supported homeless patients to access the practice without fear of stigma or prejudice. They told us that homeless patients used the practice address to register with the practice. Staff we spoke with demonstrated sensitivity to homeless patients' needs and described how they did not ask them for their address to avoid embarrassment.

Care planning and involvement in decisions about care and treatment

The national 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 87% felt the GP was good at explaining treatment and results. Seventy-eight per cent of practice respondents said the GP involved them in care

Are services caring?

decisions. This was slightly below the CCG regional average. However, the results from the PPG satisfaction survey showed that 84% of respondents said they were sufficiently involved in making decisions about their care and 91% said that the GP was good at explaining treatment and results.

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

Most patients registered at the practice had English as their first language. Staff told us how they accessed translation services if a patient did not have English as a first language.

There were 28 patients on the practice's learning disabilities register. We saw that all these patients had received an annual health review carried out using the Cardiff Health Check template to ensure a systematic review of their health and medication. At the end of the review the patient was provided with a health action plan which was agreed with them. There were 68 patients on the practices' register for patients experiencing poor mental health. There was a system in place to ensure that patients experiencing poor mental health received an annual health review. We saw there was a care plan template to enable GPs to plan the care for these patients.

The staff told us that the recall system for patients with long term conditions, such as diabetes or high blood pressure, had recently been updated. Patients were called for a review of their care and treatment around their birthday. The practice not only offered annual health reviews but held an in-house support group for patients with chronic fatigue and Myalgic Encephalopathy (ME) to ensure patients were supported in decisions about available care and treatment.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of patients surveyed said the last GP they saw or spoke with was good at treating them with care and concern. This result was above the CCG regional average. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was a carer and identified patients that were cared for. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice employed a community and care co-ordinator (C&CC). The C&CC ran an in-house, twice monthly, bereavement support group for patients at the practice. The group was facilitated by two counsellors and one to one support was also available. The group linked in with a follow-on group called Compassionate Friends which met fortnightly. A GP told us how they had recently invited a patient to the group who had suffered bereavement several years ago because they were still struggling with their loss.

In response to a research project carried out by medical students at the practice in November 2012 and working with the local community, church, schools and hospice, the practice had helped to establish Compassionate Communities (Co Co). Co Co was a voluntary service which the C&CC worked with to help to reduce loneliness and social isolation. A team of volunteers offer one-to-one support for patients in their own homes providing practical help or a befriending service. We saw application forms in the waiting area encouraging patients to volunteer or to use the service and safeguarding checks were managed through the local hospice.

In response to an Engaging Teenagers research project undertaken by medical students at the practice, the C&CC was extending their work to include younger, lonely patients. The C&CC ran an in-house dementia carer's group to ensure patients and their carers were fully involved in decisions about their care.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Local 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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, the practice manager showed us documented evidence of how they were working with the CCG to identify and meet the changing health needs for the expanding local population as a result of the new housing developments within Shrewsbury. We saw that they were proactively trying to engage with the local council to identify healthcare planning and identify what additional health resources would be required.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the Patient Participation Group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. For example, through the PPG survey it was identified that patient satisfaction with getting an appointment with a GP, including a preferred GP or any GP for urgent and routine need had fallen. We saw that an analysis of how appointments were allocated had been carried out and an action plan put in place to improve the access to appointments. We saw that as a result of these changes, the weekly appointment capacity had been increased. The practice had plans in place to review the effectiveness of these changes at the next patient survey.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had initiated positive service improvements for its patients that were over and above its contractual obligations. To meet the needs of patients whose circumstances may make them vulnerable, the practice had identified a lead GP for patients with learning disabilities. Patients with learning disabilities were offered an annual health assessment and provided with easy read information to support them to access services. For patients who were house bound, home visits were provided and where needed support was provided through Compassionate Communities (Co Co). Co Co is a voluntary service supported by the practice through their community and care co-ordinator (C&CC). Its aim is to reduce loneliness and social isolation. There was a register of patients who may be living in vulnerable circumstances and a system for flagging vulnerability in individual patient records. We saw that the practice had several homeless patients that they provided care and support for. Staff we spoke with demonstrated sensitivity to their needs and described to us how they worked closely with Shrewsbury Ark, a charity for homeless people, in contacting patients and arranging follow up health assessments. They also worked with Shropshire Independent Advocacy Service (SIAS) to assist patients experiencing poor mental health in accessing health care services.

The GPs carried out weekly ward rounds in two of the care homes they provided care for to ensure that older patients living in care had opportunities to access health care. The practice provided GP support to a 12 bedded rehabilitation unit in one of the nursing homes. This included 12 step down beds for patients whose vulnerability meant they needed additional support following discharge from hospital. We spoke with the manager from this nursing home who told us that the system was responsive to patients' needs due to twice weekly routine visits by GPs and multi-disciplinary team working.

The premises and services had been adapted to meet the needs of patients with disabilities. There was disabled parking available and step free access to the electronic entrance doors. A wheelchair was available for patients upon request. The practice was situated on the ground floor of the building with easy access to the reception area. 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.

Access to the service

Appointments were available from 8.30am to 6pm Monday to Friday and could be booked six weeks in advance. Extended access appointments were available Monday

evenings from 6.30pm to 8pm, alternate Thursday evenings from 6.30pm to 8pm and alternate Saturday mornings from 9am to 11am. This supported working age patients and children and young people to access appointments outside of normal working hours. We saw that the reception manager carried out regular audits to ensure that there were enough appointments to meet patient need.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments on-line. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed their call was diverted directly through to the Out of Hours service, Shropdoc. Information on the out of hours service was provided to patients in the waiting room and through the practice's website.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four local care homes on a specific day each week, by a named GP and to those patients who needed one.

Data from the national patient's survey demonstrated that only 64% of patients found it easy getting through on the telephone to book an appointment, however 97% of respondents reported they got an appointment when needed. To try to address the issue of patients getting through to the practice on the telephone, the practice employed the help of Shropdoc to assist the practice with patient calls in the morning. Patients were generally satisfied with the appointments system once they got through on the telephone. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. For example, one patient told us that they had rung for an urgent appointment and was seen that day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information on how to complain was displayed in the waiting room and on the practice's website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One of the patients we spoke with on the day of our inspection told us about a compliant that they had about the service. We saw that the complaint was handled effectively by the practice manager and resolved to the patient's satisfaction.

We looked at 14 complaints received in the last 12 months and found they had all been reviewed and analysed in a timely way and that there was openness and transparency in dealing with the compliant. For example, we saw that a patient had complained regarding the length of their wait to be seen by a GP Registrar. We saw that the complaint had been analysed and the GP Registrar induction procedure had been changed to prevent the incident reoccurring.

We saw evidence that the practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. The practice manager showed us an audit of the complaints and staff told us they were informed of the results of this audit through management and group team meetings.

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 practice values were part of the practice's business plan for 2013 - 2014. The vision and practice values were clearly displayed in the waiting areas and on the practice's website. The practice mission statement said that the practice recognised patients lifelong health needs and that they aimed to treat patients as individuals, combining excellent up-to-date innovative skills with traditional service values. This was underpinned by their practice values which included; providing high quality general medical services to patients ensuring patients were at the centre of everything they did; providing these services in a safe, professional and comfortable environment through continual updating of clinical skills and training specific to staffs' individual needs.

The practice had also developed core values to be shared among partners and staff. These included to be the best GP practice; to ensure an enjoyable place to work with regard to staff relationships and friendships; job satisfaction; pleasant working environment; positive feedback; good communication links and networks and manageable workloads.

We spoke with 11 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us there was an open culture within the practice and that their opinions were listed to, respected and acted on.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the practice's computer system. We looked at several of these policies and saw that some dated back to 2010. This was because a computer virus had entered the practice's computer system resulting in a loss of much of the practices information. We saw evidence confirming that the supplier of the new computer system had failed to back up the information held on the computer resulting in a major loss of information. The practice had implemented their business continuity plan to manage the loss of governance and financial documents. We saw that the business continuity plan had been effective with no disruption to patient care. Staff confirmed that prior to the computer virus all policies had been updated. The company that supplied the computer system were working with the practice to continue to recover lost information. We saw that the practice used an on-line training package that identified essential training each member of staff needed to complete for their role. We saw that when a member of staff completed a training module, they were directed to the policy related to that training and signed to confirm that they had read and understood it.

The practice held fortnightly partners' meetings and monthly operational management meetings to discuss governance issues. Regular staff meetings took place where information was shared with partners and other staff groups. We looked at minutes from the meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is a national performance measurement tool. The QOF data for this practice showed it was performing above national standards by obtaining 99 QOF points out a possible 100. We saw that QOF data was regularly discussed at partners' meetings and action plans were produced to maintain or improve outcomes.

The practice used clinical audits to monitor quality and to identify if action was required to improve outcomes for patients. The practice had completed a number of clinical audits, for example the prescribing of Clopidogrel, a medicine that inhibits blood clots. We saw that an audit had been completed which identified issues around recording the appropriate duration the medicine was to be prescribed for. We saw that changes were made to the way the prescription instructions were written and recorded to ensure patients received the medicine in line with national guidelines and the advice of their hospital Consultant. Following a second audit, the recording of the duration the medicine was to be prescribed for had increased from 40% to 77%. Where the duration had not been recorded, it was because the patient required long term treatment rather than for a specific period.

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 loss of domestic services or information technology; Control of Substances Hazardous to Health (COSHH); fire safety; buildings maintenance; access to appointments and prevention of the legionella

Are services well-led?

Good

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

virus. We saw that when risks had been identified, for example the loss of information due to a computer virus, that action plans had been put in place and discussed at staff meetings. However, we saw that blank prescription forms used by GPs on home visits were not always handled in accordance with national guidance. Serial numbers of prescriptions pads were not recorded to prevent the risk of access to medicines in the event of theft of the GPs' prescription pads.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example there was a lead nurse for infection control and one of the GPs was the lead for safeguarding. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and information governance which were in place to support staff. Staff showed us how they accessed these policies if they needed to refer to them. The practice had a whistle blowing policy which was available to all staff via the computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public,and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through their Patient Participation Group (PPG), patient surveys, complaints and compliment cards. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. We looked at the results of the practice's annual patient survey and saw that patient satisfaction in seeing their GP of choice had dropped from 84% to 31%. We saw that the practice had identified reasons for this and, along with the PPG, put an action plan in place to try to address this issue. They plan to review the effectiveness of the changes during their next patient survey.

The practice had an active PPG. We spoke with a representative from the group prior to our inspection who told us that the group was listened to and worked closely with the practice. The PPG contained 12 representatives aged 50 to 70 years of age. There was a mixture of male and female members with an additional 40 patients who supported the group in areas such as fund raising and carrying out surveys. The PPG held six general meetings a year and an annual general meeting each April. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. The PPG worked with the practice to identify the need for additional resources and equipment. The PPG had recently raised funds to purchase two hydraulic couches to meet the needs of disabled or older patients.

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. One member of staff told us that they had asked for support and funding to train as an advanced nurse practitioner and they had been fully supported to do this. There was a system in place for staff groups to receive team appraisals for two years then an individual appraisal in the third year. Staff told us they preferred this style of appraisal because it helped to resolve any issues between staff, identified team and personal objectives and improved team building.

The practice had been a GP training practice for GP Registrars (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine) and medical students since 1960. There was a lead GP responsible for the induction and overseeing of the training for GP Registrars and medical students. The ethos of learning and improvement in terms of knowledge and skills was evident throughout the inspection. For example, we saw that

Are services well-led?

Good

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

through research projects, previous medical students had identified two improvements to the service. These included the need for greater engagement with teenagers and the introduction of a voluntary service to reduce loneliness and social isolation for patients whose circumstances may make them vulnerable. We saw that the practice had implemented the recommendations of these research projects to improve outcomes for patients. The practice had supported a member of staff who originally came to the practice by an apprenticeship scheme to develop the role of a community and care co-ordinator (C&CC) to facilitate these improvements.

The practice had completed reviews of significant events and other incidents and shared with staff through bi-monthly significant events meetings to ensure the practice improved outcomes for patients. For example, the carer of a patient with a long term condition had raised concerns regarding the care the person had received. We saw that the significant event had been investigated and guidance to prevent this issue occurring again had been put in place. We spoke with one staff member who was aware of the changes needed and they described how they had implemented the changes for a patient with the same condition.