

Dawley Medical Practice

Quality Report

Dawley Medical Practice

Webb House

Telford

TF4 2AA

Tel: 01952 630500

Website: www.dawleymedicalpractice.co.uk

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dawley Medical Practice on 2 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for the following population groups; 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 and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said that although they had to wait 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There were areas of practice where the provider needs to make improvements.

Importantly the provider should:

Summary of findings

- Continue to review recruitment procedures to ensure that all staff who are involved in the direct care of patients such as providing treatment or chaperone duties are risk assessed to determine if a Disclosure and Barring Service (DBS) check is required.

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?

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. The practice had not completed full recruitment procedures for all staff involved in chaperone duties. Risk assessments had not been completed to determine if a Disclosure and Barring Service (DBS) check was required. Appropriate action was taken by the practice manager at the time of the inspection to address this. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were mixed. Data was generally similar to the locality average. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. There was plenty of supporting information to help patients understand and access the local services available. We also saw that staff treated patients with kindness and respect.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was

Good



Summary of findings

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.

Are services well-led?

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

Good



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

The practice is rated as good for the care of 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, end of life care and avoiding unplanned hospital admissions. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice provided a service to two care homes. The practice had a designated named GP for patients aged 75 and over and care plans were in place for these patients.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had an annual review to check that their health and medication needs were being met. This included services such as spirometry and 24 hour blood pressure monitoring.

Good



Families, children and young people

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 had a high number of A&E attendances. Immunisation rates were in line or higher than the local average 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, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice provided baby immunisations, weighing and six week checks. The midwife visited the practice once a week and there were immunisation clinics available. There were appointments for children available outside core school hours.

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

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 reflects the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability. The practice did not have a register of patients living in vulnerable circumstances such as homeless people or travellers, but would offer a service to patients if needed.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Data showed that 93.8% of patients on the practice register who experienced poor mental health had been offered an annual health check. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

As part of our inspection process, we asked patients to complete comment cards before our inspection. We received 19 comment cards, spoke with one member of the Patient Participation Group (PPG) and spoke with eight patients. All comments received indicated that patients found the staff helpful, caring and polite and the majority described their care as very good. Our findings were in line with results received from the National GP Patient Survey.

The July to September 2014 and January to March 2015 national GP patient survey showed that these experiences were also expressed in the survey and the practice performed well in all areas. These included:

- 78% of respondents with a preferred GP said that they usually got to see or speak to that GP as compared with the local CCG average of 59%.
- 96% of respondents said that the last GP they saw or spoke to was good at giving them enough time as compared with the local CCG average of 87%.
- 79% of respondents said that they found it easy to get through to this surgery by phone as compared with the local CCG average of 71%.
- 47% of respondents said that they usually waited 15 minutes or less after their appointment time to be seen as compared with the local CCG average of 68%.
- 75% of respondents said that they found the receptionists at the surgery helpful as compared with the local CCG average of 86%.

Areas for improvement

Action the service **SHOULD** take to improve

- Continue to review recruitment procedures to ensure that all staff who are involved in the direct care of patients such as providing treatment or chaperone duties are risk assessed to determine if a Disclosure and Barring Service (DBS) check is required.

Dawley Medical Practice

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, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Dawley Medical Practice

The Dawley Medical Practice is situated in the Dawley area of Telford. The practice is located in a purpose built property. At the time of our inspection there were 10300 patients on the practice list.

The team of clinical staff at Dawley Medical Practice consists of five GP Partners, three practice nurses and two healthcare workers. The clinical team is supported by a practice manager, reception, administrative and secretarial staff. The practice is open from 8.30am to 6pm on Monday to Friday. Extended hours are available on Tuesday evenings between the hours of 6pm and 8pm. The practice offers an open appointment system every weekday morning between the hours of 8.30am to 10am. Bookable appointments are available each afternoon. Patients can book appointments in person, on-line or by telephone.

The practice has a General Medical Services (GMS) contract with NHS England for delivering care services to their local community. A GMS contract is a contract between General

Practices and NHS England for delivering primary care services to local communities for example; various immunisation and learning disabilities and health check schemes.

The practice is a training practice for Foundation Year 2 medical practitioners (FY2) and medical students to gain experience and higher qualifications in general practice and family medicine. FY2 is a medical practitioner who is undertaking the medical Foundation Programme a two-year, general postgraduate medical training programme. During the 2nd year, FY2 Doctors can elect to undertake a four month post in General Practice. There were no FY2 medical practitioners receiving training at the practice at the time of inspection.

The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to the out of hours service, Shropdoc when the practice is closed.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

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:

Detailed findings

- 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)

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 2 July 2015.

We spoke with a range of staff including five GPs, two practice nurses, a healthcare assistant, reception staff and administration staff, on the day. We sought views from patients, a representative of the patient participation group, looked at comment cards and reviewed survey information.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw that an incident had occurred whereby empty flu vaccinations were put back into the fridge with unused vaccinations. We saw that appropriate action had been taken and the issue raised as a significant event with clinical staff. The importance of the appropriate disposal of sharps and potential harm was discussed with staff. Following analysis of the significant event we saw that the sharps disposal policy and infection control policy were reinforced with staff and policies updated.

We reviewed safety records, incident reports and minutes of monthly significant event meetings where these were discussed. There were records of significant events that had occurred during the last year and we were able to review these. We saw that the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The practice manager was responsible for disseminating safety alerts and there were systems in place to ensure they were acted on.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents. These were collated by the practice as significant events, complaints, compliments and accidents. Records we examined five significant events that had occurred over the past 12 months, (2014-2015). We saw that significant events were a standing item on the practice meeting agenda. There was evidence that the findings were shared with relevant staff. The minutes of the meetings showed that they were attended by both clinical and non-clinical staff. Staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We saw that significant event reports detailed the event, the outcome of investigations, action to be taken to prevent reoccurrence and details of the learning shared with all staff. Staff we spoke with confirmed this.

Staff used significant event forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. Of the five significant events we tracked three and saw records were completed in a timely manner. Staff we spoke with told us that a review of practice had been implemented for example following an incident where a GP who dealt with a child suspected of having a high risk infection. The GP wanted to administer an antibiotic but found that the date had expired on the medicine. The antibiotic was administered by the paramedics who attended the surgery to transfer the child urgently to hospital.

Following the incident staff at the practice reviewed procedures in place for checking medicines in the surgery and in doctor's bags to ensure they were up to date and fit for use. However we found that the system for checking medicines was not robust as medicines found in GP bags at the inspection were out of date. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at monthly staff meetings to ensure all staff were aware of any action they needed to take. One of the clinical staff told us that following receipt of a safety alert a search would be carried out dependent on the content of the alert to identify any patients that might be affected by the medicine or equipment identified as a concern.

We saw that significant events were followed up and referred or shared with other professional agencies outside the practice where appropriate. The local Clinical Commissioning Group (CCG) who monitored the performance of the practice told us they had no concerns about this practice. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further

Are services safe?

guidance if staff had concerns about a patient's welfare. In addition there were flow charts for guidance and contact numbers displayed within the reception area and treatment areas. One of the GPs was the lead for safeguarding.

All staff had received safeguarding children training at a level suitable to their role for child safeguarding, for example all clinicians had level three training. Staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection.

There was a chaperone policy in place at the practice for staff to refer to for support. Signs informing patients of their right to have a chaperone present during an intimate examination were clearly displayed throughout the practice and information included in the practice information booklet. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. We spoke with one of the practice nurses who clearly described to us their role and responsibilities in protecting patients from the risk of abuse and knew what action to take if they had any concerns.

We found that reception staff had not had a Disclosure Barring Services (DBS) criminal record check carried out or had risk assessments completed to ensure they were suitable to undertake their roles. Two of the receptionists we spoke with told us that they carried out chaperoning duties. We found that the receptionists were knowledgeable about this role for example they explained where they would stand when supporting a patient in this way. DBS checks are carried out to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice manager implemented appropriate action at the time of the inspection to address this. The practice manager told us that receptionists would no longer act as

chaperones. This would continue until they had implemented their plans to select a number of reception staff to undertake a chaperoning role, a risk assessment and DBS check would then be completed.

Medicines management

We checked the medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. A log of the fridges' temperature ranges had been recorded daily which demonstrated that vaccines in the fridges were stored in line with the manufacturers' guidelines. There was a clear policy for ensuring medicines were kept at the required temperatures and staff were aware of the need to adhere to the policy. Although systems were in place to check medicines were within their expiry date and suitable for use we found out-of-date medicines in two of the GP bags.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions 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 all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines.

We saw records of audits that identified best practice actions to be taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing for various illnesses that patients presented with. The CCG pharmacist also supported staff when reviewing the medicines of patients with long term conditions such as Asthma.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that blank prescription pads were not completely handled in accordance with national guidance. For example appropriate records were not maintained to demonstrate accurately the number of prescriptions issued. We also found that not all GP bags were suitable for their purpose for example, they were not lockable and we noted that two contained medicines that were out of date. Action to remedy this was taken at the time of the inspection by the lead GP and practice manager. This included the safe

Are services safe?

disposal of the expired medicines. Following the inspection the lead GP and practice manager sent us copies of the revised procedures for monitoring and tracking blank prescriptions and for the safe maintenance and checking of GP bags. The system for checking GP bags monthly was also reviewed to ensure that it was robust.

Cleanliness and infection control

All areas within the practice were found to be visibly clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice to be clean. Treatment rooms had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons available. Hand gels for patients and staff were available throughout the building. Clinical waste disposal contracts were in place and spillage kits were available.

One of the practice nurses was the clinical lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy, and to carry out staff training. Records we saw showed that all staff had received infection control and prevention training specific to their role during their induction period. Staff had also received ongoing training in this area to ensure that they were up to date. The practice had an infection control policy in place and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. We saw evidence that a full infection control audit was completed in December 2014. An action plan had been completed to address all improvements needed and plans put in place to repeat the audit and undertake other infection control related audits such as hand washing.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). Records were available to confirm that a legionella risk assessment was completed in February 2015. Further records confirmed that the practice was carrying out regular checks in line with their policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us there was enough equipment to help them carry out examinations, assessments and

treatments. All electrical and clinical equipment was checked to ensure they were safe to use and worked properly. We saw records that demonstrated that all medical devices had been calibrated in October 2014 to ensure the information they provided was accurate. Records available also confirmed that all portable electrical equipment had been tested in June 2015 to ensure they were safe to use. For example blood pressure measuring devices, weighing scales, thermometers and ear syringes were annually calibrated. Documentation available showed that the practice nurse carried out monthly checks on emergency equipment such as the defibrillator.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken for most staff prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However at the time of our inspection staff records we examined showed that the healthcare assistant and administration and reception staff had not had DBS criminal record checks or risk assessments completed to determine if one was required.

The practice manager told us that a DBS check had been carried out for the healthcare assistant and the outcome of this was in the process of being followed up. We were told that the plans were to select a number of reception staff that would be appointed as chaperones. Staff appointed would have DBS checks completed.

The practice had recently successfully appointed a new partner after one of the partners had left. The practice staff had also identified the need to recruit another practice nurse to meet the increased number of patients presenting with long term conditions. Staff were multi-skilled to cover each other in the event of unplanned absences.

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. We saw records that demonstrated that weekly, monthly and annual checks of the building had been carried out. These included a fire risk assessment and

Are services safe?

fire drills for staff; gas safety checks; emergency lighting tests and fire alarm testing. We saw that multiple risk assessments for the Control of Substances Hazardous to Health (COSHH) had also been completed.

We saw that where risks were identified action plans had been put in place to address these issues. We saw that a building maintenance policy was in place. Schedules were identified for maintenance. The practice had completed a risk assessment log where specific risks related to the practice were documented. We saw that each risk was rated and mitigating actions recorded to reduce and manage the risk. We saw that appropriate action had been taken to address any risks identified. For example, the condition of the practice car park presented access problems for patients with a disability that had a car. This resulted in the parking spaces being moved closer to the practice entrance.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff we spoke with told us that children were always provided with an on the day appointment if required although this may be through the sit and wait clinic held at the practice. One of the GPs told us that the local Clinical Commissioning Group (CCG) informed them of their most vulnerable patients so they could provide additional support if needed.

Arrangements to deal with emergencies and major incidents

All staff had access to an emergency buzzer or could raise an alert message through the computer system in all the consultation and treatment rooms which alerted staff to any emergency. The practice had arrangements in place to manage clinically related emergencies. Records showed that all staff had received training in basic life support in June 2014 and a schedule was in place to repeat the training. Update training for staff had been planned.

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, anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice had a defibrillator (used to attempt to restart a person's heart in an emergency) available on the premises and oxygen. All staff knew the location of this equipment and records confirmed that it was checked regularly. There was a formal medical emergency protocol in place and staff were aware of what to do if a medical emergency occurred.

The practice had a disaster handling and business continuity plan in place for major incidents such as power failure or building damage.

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 discussed with the GPs, nurses and practice manager how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. Staff we spoke with demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register learning disabilities and palliative care register.

The practice used computerised systems to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

The GPs told us they led in specialist clinical areas such as mental health, safeguarding, family planning, palliative care and diabetes. The practice nurses were qualified to support this work. Staff were encouraged to review and discuss new best practice guidelines, for example, for the management of asthma and diabetes. Our review of the clinical meeting minutes confirmed that this happened.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

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 to support the practice to carry out clinical audits.

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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice showed us two clinical audits that had been undertaken in the last 12 months. One of the audits looked at the practice's performance in relation to the national cervical cancer screening programme for patients who had a history of schizophrenia, bipolar disorder and psychosis. The audit identified 12 patients who fitted the criteria. The results showed that 83% of these patients had cervical screening carried within the previous five years. This was above the achievement threshold set for the quality and outcome framework and the national average (73%).

The practice set recommendations for targeted health promotion for patients who were infrequent attenders and those that did not respond to follow up letters inviting them to make an appointment. One of the recommendations included opportunistic discussion with patients on their perception of health screening programs during routine consultations.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor its performance in other outcomes for patients. The 2013-2014 QOF results showed that 84.7% of patients with chronic obstructive pulmonary disease (COPD) had a review completed. This was just below the

Are services effective?

(for example, treatment is effective)

local CCG average of 90.2% and 89.6% national average. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema). We saw that 98.3% of patients with asthma had received an annual review and 97.2% of patients who experienced poor mental health had a plan of care implemented. The practice had performed above the local and national averages in both these areas.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. 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 and alerts within the clinical computer system making clinical staff aware of their additional needs.

The practice was aware of, and benchmarked, its own performance within the CCG locality. Members of the practice team met with other practices within the CCG area on a regular basis.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. All staff had annual appraisals that identified learning needs from which action plans were documented. All nurses and healthcare assistants had supervision of their practice carried out. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Staff received training that included: dementia awareness, moving and handling, domestic abuse, conflict resolution, learning disabilities and information governance. There was a training schedule in place to demonstrate what training staff had received or were due to receive. The practice was closed for half a day every three months to accommodate training that was organised by the local CCG.

We noted a good skill mix among the GPs, practice nurses and healthcare assistants. The practice nurses attended local practice nurse forums and attended a variety of external training events. The practice nurses were expected

to perform defined duties and had extended roles. The nurses were able to demonstrate that they were trained to fulfil these duties. For example, the nurses had completed appropriate training to undertake the administration of childhood immunisations, vaccinations and cervical screening.

The GPs specialist interests included family planning and mental health. All the GPs we spoke with were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The practice is a training practice for Foundation Year 2 medical practitioners (FY2) and medical students to gain experience and higher qualifications in general practice and family medicine. FY2 is a medical practitioner who is undertaking the medical Foundation Programme a two-year, general postgraduate medical training programme. During the 2nd year, FY2 Doctors can elect to undertake a four month post in General Practice. There were no FY2 medical practitioners receiving training at the practice at the time of inspection.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. We spoke with the manager of a local care home. They told us the practice worked with them to meet the needs of patients and that there was effective communication between them and the practice to support the sharing of information. Monthly meetings were held to discuss the needs and treatment of patients with long term conditions, palliative care needs vulnerable and older frail patients who were at high risk of unplanned hospital admissions. These were attended by other professionals including district and palliative care nurses.

The practice encouraged other professionals to work at the practice thereby giving patients local access to a range of professionals. These included community midwives, physiotherapists, district nurse team and the community pharmacist.

The practice received blood test results, X-ray results, and letters from the local hospital including discharge

Are services effective?

(for example, treatment is effective)

summaries, out of hours GP services and the 111 service 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 GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and responsibilities.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out of hours provider to enable patient information to be shared in a secure and timely manner. We saw evidence that the practice had used significant events to learn and improve information sharing between the practice and other providers.

The practice had systems in place to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained to use the system. This system enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

All the clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Staff were also aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff had received training in the mental capacity act.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The healthcare assistant actively engaged patients in lifestyle programmes. The practice had performed better than other practices in the local CCG area for monitoring and supporting patients who smoked. Information showed that 91.7% of patients had their smoking status recorded and 90.3% of these patients had accepted support to help them stop smoking. We were told that patients were sign posted to weight loss clinics when appropriate.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2013 -2104 showed that performance for all childhood immunisations was above average or comparable with the local CCG average. Practice nurses used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition. The practice website contained health advice and information on long term conditions, with links to support organisations.

We saw that the uptake for cervical screening for women between the ages of 25 and 64 years was 68.5% which was slightly below the local CCG average of 74.1% and national average of 74.3%. The practice was proactive in following these patients up and sent reminder letters and took the opportunity at consultations to carry out these procedures. Public Health England National data showed that the practice was comparable with local and national averages for screening for cancers such as bowel and breast cancer. Last year's performance for all immunisations which included vaccinations for older patients was above average for the local CCG. There was a clear policy for following up non-attenders.

We saw that up to date health promotion information was displayed, available and easily accessible to patients in the waiting area of the practice.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous, caring and very helpful to patients both at the reception desk and on the telephone. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in July 2015. The survey included responses collected during July to September 2014 and January to March 2015. There were 330 survey forms sent out of which 110 (33%) responses were returned.

The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed the practice was rated broadly in line with the local and national average satisfaction scores on consultations with GPs and nurses and the support received from receptionists.

- 96% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 94% said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 85% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 85% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 93% and national average of 92%.
- 82% said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 19 completed cards. The cards contained positive comments about the practice and staff. Patient comments said that the service was excellent, prompt, they were treated with respect and dignity and that GPs and staff were professional, caring and considerate at all times. We also spoke with seven patients on the day of our inspection which included one member of the patient participation group (PPG). PPGs are a way for

patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

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 saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Staff told us that a quiet area could be made available if patients wanted to have a discussion in private. The practice had a confidentiality policy in place and all staff were required to sign to say they would abide by this as part of their employment contract.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients felt that they were generally involved in planning and making decisions about their care and treatment and generally rated the practice similar to the local and national averages. For example:

- 83% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 90%.
- 86% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%.
- 83% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 89% and national average of 90%.
- 83% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 85%.
- 96% said that they had confidence and trust in the last GP they saw or spoke to compared to the CCG average of 94% and national average of 95%.
- 99% said they had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 97% and national average of 97%.

Are services caring?

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 were 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.

Staff told us that translation services were available for patients who did not have English as a first language. This enabled them to be involved in decisions about their care. We saw there were notices in the waiting area and information on the practice website informing patients this service was available. Patients were also encouraged to use their own translator if they wanted to.

Patients were told how long it would be before their test results were received by the practice. Patients were made aware that they would be advised on whether they needed to make an appointment to discuss their results with the GP. Patients were reminded in an information leaflet that test results could only be released to the person to whom they related or someone who had been given prior permission in keeping with confidentiality and data protection guidance.

Patient/carer support to cope emotionally with care and treatment

Practice staff were knowledgeable about their patients and were aware of patients that were also carers. The practice kept a list of patients who were carers and alerts were on these patients' records to help identify patients who may require extra support. There was supporting information to help patients who were carers on a notice board in the waiting room. The patient 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:

- 97% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.
- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.

Staff described the support they provided for carers and the organisations patients were signposted to for additional support where needed. These included a counselling service for professional support such as family members after bereavement. A patient's comments confirmed this and described the empathy and understanding they received following a family bereavement.

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. For example, the practice had a higher than average number of patients aged between 45 and 79. The practice provided services to ensure their needs could be met. For example, patients were offered health screening and extended hours were available on Tuesday evenings between the hours of 6pm and 8pm for patients of working age. The practice also had a high percentage of teenage pregnancies within the community they provided a service to. The practice worked closely with external agencies, which included midwives, health visitors and social services to support these patients.

The practice worked closely with other professionals to support the care and treatment of patients. Some of the professionals worked from the practice and they included physiotherapists and a podiatrist. A counsellor was employed by the practice to help support the needs of patients who presented with emotional and stress related difficulties. There was also a psychologist attached to this practice who provided support for patients who experienced poor mental health.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements. For example the practice had signed up to a CCG led service for patients with dementia to promote early diagnosis and intervention.

The practice had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available on the waiting room noticeboard and in the practice newsletters. The PPG met quarterly and patient surveys were sent out annually. We spoke with a member of the group who told us the practice had been responsive to their concerns. For example, late night appointments were introduced following feedback from the PPG.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. The practice was a two storey building, providing clinical treatment for patients on both floors. The first floor was accessible by a lift or stairs. The waiting area was not large but patients with wheelchairs and prams were able to access treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included designated parking spaces, level access to the automatic front doors of the practice, and toilets for patients with a physical disability. Access to baby changing facilities was available.

The practice had a small population of patients whose first language was not English; staff had access to translation and interpretation services to ensure patients were involved in decisions about their care. The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system.

The practice had an enhanced contract to provide a service to patients in the Telford area who had been de-registered from other practices in the area due to unacceptable behaviours. There was pro-active planning for the care of patients who had caused difficulties in their previous practice. The practice staff developed agreements with these patients on attendance at the practice and how they could best work together to best meet their expectations. Monitoring of the patient demonstrated that a stable interaction with the practice was established.

We saw that staff had received training in equality and diversity, managing aggressive people, customer care and that there were policies in these areas for them to refer to. Staff told us that if they had any concerns or observed any threatening behaviours, instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. All staff had access to an emergency buzzer or could raise an alert through the computer system if needed.

Access to the service

The practice was open from 8.30am to 6pm on Monday to Friday. Extended hours were available on Tuesday evenings between the hours of 6pm and 8pm. The practice offered

Are services responsive to people's needs?

(for example, to feedback?)

an open appointment system every weekday morning between the hours of 8.30am to 10am. Bookable appointments are available each afternoon. Patients could book appointments in person, on-line or by telephone

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 through the website. 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, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for older patients, children, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions.

The patient survey information we reviewed for July 2015 showed that patients rated the practice average when compared to local and national averages in response to questions about access to appointments. For example:

- 79% were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 73% described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.
- 74% said they could get through easily to the surgery by telephone compared to the CCG average of 71% and national average of 73%.

Patients rated the practice poorly for waiting after their appointment time compared to the local and national average. The results showed that:

- 47% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%.

The patient views in the comments cards we received showed that patients were happy with the appointment

system. Comments made said that they liked the walk in clinic because they were always seen. However patients we spoke with expressed some concerns about waiting to be seen. This was particularly related to the morning walk in clinic. Patients also said that there was up to a two week wait for an appointment at the afternoon clinics. Practice staff told us that patients had been made aware that there may be a wait to be seen at the walk in clinic. The appointment system showed that there was a six day wait for the next routine appointment. The PPG had carried out a survey with the support of the practice to look at this. The outcome determined that patients were happy with the appointment system and did not want to change the walk in clinic system.

Listening and learning from concerns and complaints

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

Information about how to make a complaint was available on the practice's website and in the waiting area. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy and patient complaint leaflet outlined who the patient should contact if they were unhappy with the outcome of their complaint.

We looked at a summary of eight complaints made during the last 12 months and saw they had been responded to in line with the practice's complaints policy with a full explanation and apology. Complaints were raised as significant events where appropriate and investigated. The practice discussed complaints with staff at the appropriate staff meeting and was able to demonstrate changes made in response to feedback. An annual review meeting was also held. The last meeting was held in April 2015 and minutes were available to confirm this.

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 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 statement of intent and patients' charter. We saw that these were displayed in the practice and included working in partnership with patients to ensure they were involved in decisions about their treatment. The practice would ensure that all members of the practice team were competent and motivated to deliver the required standards of care. Patients confirmed that they were involved in making decisions about their care and records we looked at showed that staff were trained to carry out their role.

The practice did not have a formal written business plan in place but all staff were clear that the main priority was the development of the premises and ongoing recruitment of staff.

The practice engaged with the local Clinical Commissioning Group (CCG) to ensure services met the local population needs. Comments we received from patients reflected the practice's vision in that patients felt they received high quality safe care and services.

Staff we spoke with knew and understood the vision and values for the development of the practice. Staff knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of meetings held at the practice and saw that staff had discussed and agreed the vision and values for the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in folders, on the desktop on any computer within the practice. We looked at five of these policies and procedures for example, health and safety and staff had completed a cover sheet to confirm that they had read the policy and when. All five policies and procedures we looked at had been reviewed annually and were up to date.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, for example loss of the computer system. In the event of the loss of the main computer operating system, practice

staff had identified alternative computers and installed a back-up computer system to allow staff to access patient information. We saw that the risk log was discussed at meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. We saw that assessments were reviewed annually.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for immunisations and one of the GP partners was the lead for mental health. All the staff we spoke with were all clear about their own roles and responsibilities. All staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed that they had achieved 88.3% of the points available compared with a national value of 93.5%. We saw that QOF data was regularly discussed at monthly meetings and actions had been taken to maintain or improve patient outcomes.

The practice had a programme of clinical audits to monitor quality and systems to identify where action should be taken. Audits previously carried out were related to the validation of QOF information, clinical audit practice and medicine reviews.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies,

Are services well-led?

Good 

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

for example recruitment and disciplinary procedures which were in place to support staff. We were shown the staff handbook that was available to all staff which included sections on equality, whistleblowing and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, compliments and complaints received. We looked at the results of the patient participation group (PPG) patient survey for 2014 and saw appropriate action was taken to address comments and suggestions made by patients. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had an active PPG which consisted of eight members. The PPG included male and female members from mainly the older population group. The group was actively working to recruit members from other population groups and had approached for example the mother and baby groups to promote interest. They had also posted adverts in the waiting room to encourage patients to join the group. The PPG met quarterly with staff members and a GP from the practice.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had gathered feedback from staff through staff meetings, 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 and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff files we looked at demonstrated that regular appraisals had taken place which included clear personal development and training plans. We saw examples of these that confirmed this. Staff told us that the practice was very supportive of training and that they had protected learning time where guest speakers and trainers attended. We saw that the practice had a training matrix that identified when staff training would need to be updated.

The practice had completed reviews of significant events and other incidents and shared these with staff at monthly meetings to ensure the practice improved outcomes for patients. We saw minutes that confirmed this.

We saw that the practice worked extremely well as a team and worked to make and sustain improvements. The practice GPs met informally on a weekly basis to discuss any clinical issues, guidelines or serious events.