Ellesmere Medical Practice

Quality Report

Trimpley Street
Ellesmere
Shropshire
SY12 0DB
Tel: 01691 622798
Website: ellesmeremedicalpractice.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 Ellesmere Medical Practice 18 June 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 older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings across all the areas we inspected 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 leaving medicines for collection at a local hairdresser.
- 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.
- 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.

We saw the following areas of outstanding practice:

- The practice had used the NHS strategy, 'Five Year Forward View' to develop their vision for the way in which they would lead and develop services to meet the future needs of their patients. This included the development of a multispecialty hub to work in

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partnership with and integrate with other services, agencies and professionals. They had met with the clinical commissioning group (CCG) to discuss putting forward a business plan to develop this.

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

Importantly the provider should:

- Review significant events and complaints over time to identify any themes or trends.
- Carry out a risk assessment to ensure that medicines left for collection at a local hairdresser are handled appropriately. This should include, the safe storage of medicines at the hairdresser, how patient confidentiality is maintained and checks that the person storing the medicines is a fit and proper person to do so. The practices' dispensing standard operating procedures should be updated to include how these checks are to be carried out.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. However there was no system in place to review significant events over time to identify themes and trends. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed with the exception of leaving medicines for collection at a local hairdresser. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included 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 to meet the needs of patients. For example, patients receiving end of life care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the need for a new practice to meet the needs of the increasing population living in Ellesmere. The practice had worked with the patient participation group (PPG) to improve telephone access to the practice to book appointments. A PPG is a group of

Summary of findings

patients registered with a practice who work with the practice to improve services and the quality of care. Patients could book appointments in advance with urgent appointments available the same day. Ten minute appointments were offered to patients but every third appointment was blocked in case patients required more time to ensure their needs were met. This provided an average consultation time of 15 minutes per patient.

Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy which had been shared with all staff members. All the staff we spoke with were clear about the vision and their responsibilities in relation to this. Different staffing groups had developed their own departmental mission statement in line with the overall practice vision. There was a very clear leadership structure and staff felt supported by the 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 PPG was active and worked with the practice to improve the service for other patients.

The practice had used the NHS strategy, 'Five Year Forward View' to develop their vision for the way in which they would lead and develop services to meet the future needs of their patients. This included the development of a multispecialty hub to work in partnership with and integrate with other services, agencies and professionals. They had met with the clinical commissioning group (CCG) to discuss putting forward a business plan to develop this.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had identified their most vulnerable patients and had completed 124 care plans to help to prevent avoidable hospital admissions for these patients. The practice employed two care co-ordinators to support this work. The practice recognised that the number of older people registered with the practice would increase in the future and were working the clinical commissioning group (CCG) to develop services to meet the future needs of older patients.

People with long term conditions

Good

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 were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were high for most standard childhood immunisations and the practice had made effective changes to their service to increase the uptake of childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. The practice recognised the specific needs of young patients and told us they were working towards the 'Your Welcome' award to improve how these patients were supported.

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Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances. For example, there were 29 patients on its register for people with a learning disability. We saw that 76% of these patients had received an annual medication review in the previous 12 months. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The care co-ordinators helped to support this work. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of normal working hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Seventy-three per cent of people experiencing poor mental health and 88% of patients experiencing depression had received an annual medication review in the last 12 months. The practice had a lead GP for dementia and had developed a dementia screening and investigation pathway. The practice had signed up to the dementia diagnosis scheme and had achieved a 72.4% practice diagnosis rate which was above their target of 67%. The practice proactively managed advance care planning for patients with dementia. Staff had received training on dementia awareness.

The practice offered substance misuse clinics. One of the GPs worked closely with the local substance misuse team to support

these patients. GPs referred patients who were experiencing poor mental health or interpersonal distress such as relationship problems and social problems to an NHS counsellor. There was also a private counsellor that patients paid to receive support when experiencing poor mental health.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

Most of the 14 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 mainly positive. Patients told us the staff were always helpful, professional, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. They said that the receptionists were helpful. Patients told us that the practice was always visibly clean and tidy. We received mixed comments about the timeliness of access to appointments and the length of time patients waited to go in for their appointment. Most patients however told us the appointment system was easy to use and met their needs.

The results from the national patient survey carried out during January-March 2014 and July-September 2014 showed that 93% of patients said that their overall experience of the practice was good or very good. This was above the Clinical Commissioning Group (CCG) regional average of 90%. We looked at the most recent data from the Family and Friends test. This asked patients whether they would recommend their GP practice to their friends and family if they needed similar care or treatment. We saw that 76.5% of respondents said they would recommend this practice.

Areas for improvement

Action the service SHOULD take to improve

The provider should review significant events and complaints over time to identify any themes or trends.

The provider should carry out a risk assessment to ensure that medicines left for collection at a local hairdresser are handled appropriately. This should include, the safe storage of medicines at the hairdresser, how patient confidentiality is maintained and checks that the person storing the medicines is a fit and proper person to do so. The practices' dispensing standard operating procedures should be updated to include how these checks are to be carried out.

Outstanding practice

The practice had used the NHS strategy, 'Five Year Forward View' to develop their vision for the way in which they would lead and develop services to meet the future needs of their patients. This included the development of a multispecialty hub to work in partnership with and integrate with other services, agencies and professionals. They had met with the clinical commissioning group (CCG) to discuss putting forward a business plan to develop this.

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Detailed findings

Our inspection team

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 Ellesmere Medical Practice

Ellesmere Medical Practice is based in Shropshire and provides primary health care to patients living in Ellesmere. It is a two storey building with automatic entrance doors to the practice and dispensary. There are 12 consultation rooms, two patient toilets, a dispensary, reception and waiting room areas are on the ground floor. The practice has a contract to provide Personal Medical Services (PMS) for patients. This is a locally agreed alternative to the standard GMS contract used when services are agreed locally with a practice which may include additional services beyond the standard contract.

The practice provides a number of specialist clinics and services. For example long term condition management including asthma, diabetes and high blood pressure. It also offers services for family planning, immunisations, health checks, foreign travel, minor illness and minor surgery. It also offers a phlebotomy service. Phlebotomy is the taking of blood from a vein for diagnostic tests.

A team of four GP partners, four practice nurses, two health care assistants, two care co-ordinators and six pharmacy dispensers provide care and treatment for approximately 7500 patients. There is also a practice manager and 10 receptionists and administrative staff. There is one female and three male GPs. The practice is a training practice for GP registrars and medical students to gain experience and higher qualifications in general practice and family medicine.

The practice is open between 8.15am and 6pm Monday to Friday. Appointments are from 8.15am to 1pm every morning and 2pm to 6pm daily. Patients can book appointments three weeks in advance with a GP and up to six weeks in advance with a nurse.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 this service under Section 60 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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 (Regulated Activities) Regulations 2014, 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.

Detailed findings

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:

- 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 held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a district nurse, health visitor and the manager of a local care home where the practice delivered care and treatment to patients living there. We also spoke with the chairperson of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We did this to help us to understand the care and support provided to patients by the practice.

We carried out an announced inspection on 18 June 2015 at the practice. During our inspection we spoke with the two GP partners, a nurse, a health care support worker and a care co-ordinator. We also spoke with a pharmacy dispenser, three receptionists, the practice manager and 14 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 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, a pharmacy dispenser told us how they had raised a significant event when a medicine was dispensed incorrectly.

We reviewed safety records, incident reports and minutes of significant event meetings where issues were discussed. We saw that staff were proactive in raising significant events and that leaning from them was shared with all staff. However, the practice had not reviewed significant events over time to identify any themes or trends.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of 59 significant events that had occurred during the last year and we were able to review these. Monthly significant events meetings were held to review and share learning from them. We saw that the practice had learned from these and that the findings were shared with relevant staff. For example, a significant event was raised following the identification of high failure to attend (DNA) rates for childhood immunisations. We saw that an audit had been carried out to understand the reasons for this and what improvements could be made. The first audit cycle showed a DNA rate of 22.4%. The practice introduced a system of calling parents/carers the afternoon before their child's immunisation. A follow up audit cycle carried out after this change showed the DNA rate had significantly been reduced to 7.8%. 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.

Staff used significant event forms to record events and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We looked at several of these significant events and saw they had been investigated in a timely manner and actions had been taken to prevent them from happening again.

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 staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

Policies for safeguarding children and vulnerable adults were available on the practice's computer system for staff to refer to or support and guidance. These contained information about identifying, reporting and dealing with suspected abuse that was reported or witnessed. All the staff had received safeguarding training at a level appropriate to their role. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information and how to contact the relevant agencies in and out of normal hours.

The practice held registers for children at risk and vulnerable families. There was a system in place to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at the accident and emergency department (A&E). There was a lead GP for safeguarding at the practice. They had been proactive in reporting safeguarding concerns and showed us two anonymous safeguarding referrals that the practice had made. We saw that appropriate action had been taken and as a result of the referrals that additional care or support had been put place to support these patients.

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. (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.

Medicines management

Medicines at the practice were stored securely. Appropriate checks and procedures were in place to make sure

Good

Are services safe?

refrigerated medicines were stored at the correct temperature. Arrangements were in place to ensure medicines including those in GPs' bags were in date. We saw that patients' repeat prescriptions were reviewed regularly to ensure they were still appropriate and necessary.

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.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) in their practice dispensary and had standard operating procedures in place that set out how they were managed. This included the destruction of out of date CDs and CDs that had been returned to the practice. We saw that the procedures had been followed by the practice staff.

The practice had systems in place to assess the quality of the dispensing process in their dispensary. For example 260 dispensing reviews of the use of medicines (DRUMS) had been completed and staff completed 'error cards' if they identified dispensing errors prior to the medicines leaving the practice. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for some patients to collect their dispensed prescriptions at a local hairdresser. However, a risk assessment had not been carried to ensure that medicines left for collection were stored safely, that patient confidentiality was maintained or that the person storing the medicines was a fit and proper person to do so. The practices' dispensing standard operating procedures did not provide guidance on this for staff to refer to.

Cleanliness and infection control

The practice was visibly clean and tidy and staff followed appropriate infection control procedures to maintain this standard. The practice carried out infection control audits and where issues had been identified action had been taken to improve in these areas. A follow up audit had been completed by the practice which demonstrated the changes made had been effective. Reasonable steps to protect staff and patients from the risks of health care associated infections had been taken. Staff had received relevant immunisations and support to manage the risks of health care associated infections. A legionella risk assessment had been completed in April 2012 to protect patients and staff from harm. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that there were procedures in place to prevent the growth of legionella. 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 who had undertaken further training to enable them to provide advice on infection control. All staff had received training about infection control specific to their role. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment maintenance logs that demonstrated that all electrical equipment had been tested and maintained regularly. For example, all portable electrical equipment had been tested in June 2015 and medical devices were calibrated in July 2014 to ensure they were safe to use.

Staffing and recruitment

There were sufficient numbers of staff with appropriate skills to keep people safe. Staff rota systems were in place and assessments for the needs of additional staff had been carried out. These took into account changes in demand, annual leave, patient requests and sickness. For example, the practice had employed a nurse practitioner to help to meet the needs of patients and provide greater choice for females to see a female practitioner. Records showed that appropriate checks were undertaken prior to employing staff, such as identification checks and Disclosure and Barring Service checks.

Monitoring safety and responding to risk

The practice had assessed risks to those using or working at the practice and kept these under review. Patients with a

change in their condition were reviewed appropriately. Patients with an emergency or sudden deterioration in their condition were referred to a duty GP for quick assessment.

Annual and monthly checks of the building had been carried out. For example, a fire risk assessment and fire drills for staff; gas safety checks and emergency lighting tests.

Arrangements to deal with emergencies and major incidents

There were emergency procedures and equipment in place to keep people safe. 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 (a severe allergic reaction) and 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. Staff had received cardio pulmonary resuscitation training, and a defibrillator was available, which staff were trained to use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of IT, adverse weather, unplanned sickness and the loss of domestic services. The business continuity plan included important contact numbers for use in the event of the loss of one of these services.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff routinely referred to guidelines from the National Institute for Health and Care Excellence (NICE) when assessing patients' needs and treatments. There was a system in place to inform staff of any changes in the NICE guidelines they used. We saw that practice protocols based on NICE guidelines had been developed for staff to refer to. For example, the management of patients with chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. We saw that the practice had also used NICE guidelines in their analysis of significant events and in carrying out clinical audits.

Practice nurses managed specialist clinical areas such as diabetes, heart disease and asthma, in conjunction with a lead GP. Care was planned to meet identified needs and was reviewed through a system of regular clinical meetings.

The GPs we spoke with used national standards for the referral of patients to other services. For example, two weeks for patients with suspected cancer to be referred and seen. The senior GP partner showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was below most other practices in the CCG. This showed that the practice prescribed antibiotics appropriately.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and outcomes. This included data for the Quality and Outcome Framework (QOF), clinical audits, and compared its performance against other practices in the CCG. 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 e.g. diabetes and implementing preventative measures. The practice had performed higher than many other practices in several areas and had achieved 100% of QOF points in 2014-2015.

The practice showed us five clinical audits that had been undertaken in the last year. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, one of the GPs at the practice had reviewed the NICE guidelines for the treatment of older patients with atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). To ensure that patients received the care and treatment recommended in this guidance, a clinical audit had been carried out. The audit cycle demonstrated that 54.5% of these patients were receiving treatment in line with this guidance. The information was shared with GPs and patients were opportunistically reviewed. Following changes made, a follow up clinical audit was completed which demonstrated that this figure had increased to 62.4%. The audit also identified future areas to consider such as how to review the remaining patients and the need for a cost/benefit analysis of the drug treatment used. Other examples included audits of 'did not attend' attend rates (DNA) for childhood immunisations, DNA rates for GP and nursing appointments, and referrals to other services.

There was a protocol for repeat prescribing that was in line with national guidance. In line with this, staff regularly checked that patients who received 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. For example, we saw that 90% of patients with diabetes, 85% of patients with COPD and 75% of patients with asthma had received an annual medication review in the last 12 months.

The practice followed the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice offered substance misuse clinics to assess and manage the care for substance misuse issues. One of the GPs worked closely with the local substance misuse team to support these patients. The practice employed a care co-ordinator to support and facilitate care for vulnerable patients. The care co-ordinator facilitated health reviews for frail older people and telephoned patients following any hospital admissions to check on their health and wellbeing.

Effective staffing

Staff had received training appropriate to their roles, and had protected learning time for on going training. They were supported in attending external courses where

Good

Are services effective?

(for example, treatment is effective)

required. Continuing professional development for nurses was monitored through appraisals, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice. There was a good skill mix among the GPs with two having additional diplomas in children's health. All the GPs 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.

Checks were made on qualifications and professional registrations as part of the recruitment process. Staff were given an induction and further role specific training when they started.

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 a district nurse, health visitor and the manager of a local care home prior to our inspection. They told us the practice worked with them to meet the needs of patients and that there were effective communication pathways in place to support the sharing of information. Regular meetings were held to discuss the needs and treatment strategies of patients with long term conditions; palliative care needs and 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 received blood test results, X ray results, and letters from the local hospital including discharge 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 system with the local GP out-of-hours provider that enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals to other services

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All the staff were fully trained on the system.

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 clinical 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 recent 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.

There was a practice policy for documenting consent for specific interventions. However, there was no reference in the practice's consent policy to the MCA 2005 for staff to refer to for support and guidance. We saw that there was a form to obtain informed written consent for minor surgery and the withdrawal of consent which were scanned into patients' records.

Health promotion and prevention

The practice offered new patient health checks, and NHS checks for patients aged 40-75. Advice was available on stopping smoking, alcohol consumption and weight management. Patients over the age of 75 were allocated a named GP. 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 for the CCG except for the 12 month meningitis C

Good

Are services effective?

(for example, treatment is effective)

immunisation. In response to this the practice had carried out an audit that looked at ways of improving the attendance rate of children for childhood immunisations. We saw that the changes made by the practice had been effective and failure to attend rates had decreased from 22.4% to 7.8%. 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.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had a register of 88 patients with a diagnosis of dementia and 74% of these patients had received an annual health check in the last 12 months. The practice had identified 845 patients over the age of 16 who smoked and 90% of these had received smoking cessation advice or been referred to 'Help2Quit'. However, only 28 of these patients stopped smoking. Similar mechanisms of identifying 'at risk' groups were used for patients who were overweight and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 82% which was above the national target of 80%. Eligible patients had been referred to screening for cancers.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 14 patients during the inspection, and collected 15 Care Quality Commission (CQC) comment cards. Comments were mainly positive. Patients told us the staff were always helpful, professional, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. They said that the receptionists were helpful.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey carried out during January-March 2014 and July-September 2014 and a survey of 554 patients undertaken by the practice's patient participation group (PPG). 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 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 showed that 93% of respondents said that their overall experience was good or very good and 80% of respondents would recommend the practice to someone new in the area. These results were in line with the regional clinical commissioning group (CCG) average of 90% and 83% respectively. The practice was above the CCG regional average for its satisfaction scores on consultations with GPs and nurses. For example, 96% of respondents said the GP, and 90% said the nurse was good at listening to them. This was above the CCG regional average of 93% and 93% respectively.

Consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. This prevented patients overhearing potentially private conversations between patients and the reception staff.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas. For example, data from the survey showed 90% of practice respondents said the GP was good at involving them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were above the regional CCG average of 87% and 91% respectively. However, 84% said the last nurse they saw or spoke to was good at involving them in decisions about their care. This was below the CCG average of 88%.

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.

Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

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, 94% of respondents to the national patient survey said the last GP they saw or spoke with was good at treating them with care and concern. This was above the regional average of 90%. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. The practice kept registers of patients who needed extra support, such as those receiving palliative care and their carers, and patient experiencing poor mental health.

Notices in the patient waiting room, on the TV screen and patient website informed patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers

Good

Are services caring?

to ensure they understood the various avenues of support available to them. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided cared for. To do this, carers were offered the 'flu vaccination and support from the care co-ordinator.

The practice had a system in place to support patients known to them who had suffered a recent bereavement. We saw that practical advice about what to do in times of bereavement was available for patients on the practice's website. The practice also sent out bereavement cards to relatives and a GP telephoned them to check on their health and welfare.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs and future needs of the practice population were clearly understood and systems were in place to address identified needs in the way services were delivered. For example, the practice were working with the clinical commissioning group (CCG) put plans in place to move to a new building that would meet the needs and future needs of their practice population.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, the instillation of electronic doors to the practice and dispensary to improve access for patients with mobility difficulties.

Tackling inequity and promoting equality

The practice had provided equality and diversity training through e-learning for all the staff. The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground and first floors of the building with services for patients provided on the ground floor. The waiting rooms were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Facilities for patients with mobility difficulties included a disabled parking space; step free access to the front door of the practice; electronic entrance doors; disabled toilets and a hearing loop for patients with a hearing impairment.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care.

The practice provided care and support to several house bound older patients and patients living in three care homes. Patients over 75 years of age had a named GP to ensure continuity of care.

There were no homeless patients registered with the practice but the practice had a small transient population as they provided care to people living on barges on the canals in the practice's catchment area. These people were supported to access the service without difficulty.

Access to the service

The practice was open between 8.15am and 6pm Monday to Friday. Appointments were from 8.15am to 1pm every morning and 2pm to 6pm daily. Patients could book appointments three weeks in advance with a GP and up to six weeks in advance with a nurse. The practice offered 10 minute appointments to patients but every third appointment was blocked in case patients required more time to ensure their needs were met. This provided an average consultation time of 15 minutes per patient if needed. The practice did not routinely provide an out-of-hours service to their own patients but patients were directed to the out of hours service Shropdoc, when the practice was closed.

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 practice's 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, they were automatically diverted to the out of hours provider, Shropdoc. Information on the out-of-hours service was provided to patients. The practice proactively monitored and audited 'did not attend' (DNA) rates for GP and nursing appointments. Changes to improve the high rate of DNAs had been discussed by the practice.

The practice's patient survey had identified dissatisfied with the appointments system. This was supported by the national patient survey carried out during January-March 2014 and July-September 2014. This showed that 73% of respondents found it easy to get through on the phone compared with the CCG regional average of 84%. Seventy-nine per cent of respondents described their experience of making an appointment as good or very good. This was below the regional average of 84%. Some patients we spoke with on the day of our inspection told us they sometimes went in late for their appointments or had

Good

Are services responsive to people's needs?

(for example, to feedback?)

difficulty getting an appointment. The practice had put an action plan in place to address these issues and we saw that the actions had been carried out. The practice planned to review the effectiveness of these changes.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated person who handled all complaints in the practice. Information on how to complain was in the patient information leaflet and on the practice's website.

We looked at a summary of 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. The practice discussed complaints with staff at practice meetings, and was able to demonstrate changes made in response to feedback, such as improvements to the appointment system. However, they had not reviewed complaints over time to identify any common themes or trends.

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. Their mission statement was, 'We aim to provide high quality, caring and patient centred services whilst embracing change and delivering innovation and creativity alongside the traditional values of general practice'. This was clearly displayed throughout the practice for staff and patients to see. All the staff we spoke with were clear about the vision and their responsibilities in relation to this. Different staffing groups had developed their own departmental mission statement in line with the overall practice vision. The practice had used the NHS strategy, 'Five Year Forward View' to develop a vision for the way in which they would like to deliver services in the future to meet the needs of their patients. This included the development of a multispecialty hub to work in partnership with and integrate with other services, agencies and professionals. We saw that they were in discussions with the clinical commissioning group (CCG) to put forward a business plan to develop this.

Governance arrangements

There was a very clear leadership structure within the practice. Staff were clear about their roles and responsibilities and felt supported by the management in these. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor quality and identify risk. Data from the Quality and Outcomes Framework (QOF) showed the practice was performing at or above national standards. The practice regularly reviewed its results and how to improve.

The practice had identified lead roles for areas of clinical interest or management. A programme of clinical audits was in place. Three of the five audits we were shown included follow up audits that demonstrated suggested changes to practice had improved health outcomes for patients. From our discussions with staff we found that they looked to continuously improve the service being offered, and valued the learning culture.

Leadership, openness and transparency

Staff we spoke with were positive about working at the practice. They told us they felt supported to deliver safe, effective and responsive care. Staff described the culture at the practice as open and transparent. The GP partner's valued partnership working and recognised the strength of having a strong, cohesive staff team.

Regular practice and departmental meetings were held at the practice and staff felt confident to raise any issues or concerns at these meetings. There was a practice whistle blowing policy available to all staff to access on the practice's 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.

Seeking and acting on feedback from patients, public and staff

There was an active patient participation group (PPG) at the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Annual patient surveys and action plans were carried out and published on the practice's website for the practice population to read. We saw an action plan to address three priority areas had been put in place. This included the addition of extra telephone lines to improve telephone access to the practice and the updating of the practice leaflet and website to inform patients of the differing roles of the practice staff. During our inspection we saw that all these changes had been made to the practice.

Staff told us they felt confident giving feedback, and this was recorded through staff meetings. A staff survey had been carried out although it had not been fully evaluated. 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 the practice supported them to maintain their clinical professional development through training and mentoring. Annual appraisals had been carried out and staff had identified learning objectives and training needs.

The practice was a training practice and supported medical students and GP registrars. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice

Are services well-led?

Good

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

and family medicine. The practice had completed reviews of significant events and other incidents, and shared these with staff at monthly significant event meetings and team meetings.