Broseley Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 22 October 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions. families, children and young people, working age people, people in vulnerable groups and people experiencing poor mental health. One example of this was the practice employed its own counsellor to support patients with mental health problems such as depression or stress and anxiety.

Our key findings were:

- Performance was consistent over time and patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred.
- Patients received evidence based assessments and care and treatment was planned and delivered to promote a good quality of life.
- Staff treated patients with kindness and compassion. Patients told us that staff were caring and treated them with dignity and respect. They said that they had confidence and trust in the GPs and nurses.
- Services were planned and delivered to meet the needs of the patients. Patients were positive about the access to appointments and the telephone consultation service.
- The leadership and management within the practice promoted an open and transparent culture. Staff felt able to contribute to the running of the service. The practice sought and acted on feedback from staff and patients.

There were also areas of practice where the provider needs to make improvements. The provider should:

- Ensure that the recruitment processes are in line with the practice's own recruitment policy and that all staff have either a criminal records check via the Disclosure and Barring Service (DBS) or have a risk assessment in place to explain why a DBS check is not needed.

Summary of findings

- Review the significant events reporting and recording system to ensure that all events that are critical (whether beneficial or detrimental to the outcome) are included and to improve the quality of patient care from the lessons learnt.
- Consider ways to strengthen the risk management processes within the practice to ensure that all risks are assessed and rated with mitigating actions recorded to reduce and manage risks, including those relating to legionella, fire safety, recruitment and electrical testing.
- Update the health and safety policies and procedures used by the practice to ensure that all requirements in the Control of Substances Hazardous to Health Regulations 2002 (COSHH) are met.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. The system for reporting significant events needed to be reviewed to ensure that all events were included and analysed to ensure ongoing improvement in patient care. Lessons were learned and communicated widely to support improvement. Systems were in place to assess risks to patients and staff, however these needed to be reviewed to ensure all potential risks were reduced and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. Staff received annual appraisals and had opportunities for ongoing professional development. Multidisciplinary working was evidenced. The practice was extremely proactive in working with other professionals and the local community.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice 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 an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in placeand referrals were made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. Home visits for elderly patients with long term conditions were carried out. 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 population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. We were provided with good examples of joint working with other professionals such as district nurses and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age population and those recently retired (including students). The needs of this population group had been identified and the practice had adjusted the services it offered to ensure services 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 which reflected the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people living in vulnerable circumstances. The practice had carried out annual health checks for people with learning disabilities and all of these patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs at the practice attended vulnerable families meetings with other health professionals to ensure the ongoing needs of these patients were met. The practice had signposted vulnerable patients to 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 hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice employed its own counsellor to support patients with mental health problems such as depression or stress and anxiety. The lead GP confirmed that the waiting times for patients to see the counsellor were extremely favourably and enabled the practice to offer access for patients to professional counselling. The practice also had access to the local community mental health team and Improving Access to Psychological Services (IAPT). The practice held a register of patients with severe mental illness and carried out health checks with them at least annually. Some staff had received training on the Mental Capacity Act 2005 and others had training on mental health awareness.

Summary of findings

What people who use the service say

We spoke with six patients on the day of the inspection. All of them were overwhelmingly complimentary about the services provided at the practice. They said that the GPs and staff were very good. They told us that all the staff were kind, compassionate and respectful. All of the patients told us that there was no problem at all getting an appointment to see or speak with a GP.

We spoke with the chair of the Patient Participation Group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. They told us that they felt well supported by the practice and the staff who attended the PPG meetings. We reviewed the 17 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection.

All of the comment cards contained extremely positive feedback about the service provided by the practice. Patients told us that all staff were kind, compassionate and respectful.

We looked at the national GP Patient Survey information published in December 2013 which found that 90% of patients described their overall experience of the practice as good. This was above the Clinical Commissioning Group's (CCG) regional average and was based on 121 responses. The chair of the PPG told us that the PPG carried out patient surveys each year and a comments box was also available in the waiting area for patients. The chair confirmed to us that any suggestions for improvement made by them or other patients were listened to and actioned by the practice.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Ensure that the recruitment processes are in line with the practice's own recruitment policy and that all staff have either a criminal records check via the Disclosure and Barring Service (DBS) or have a risk assessment in place to explain why a DBS check is not needed.
- Review the significant events reporting and recording system to ensure that all events that are critical (whether beneficial or detrimental to the outcome) are included and to improve the quality of patient care from the lessons learnt.
- Consider ways to strengthen the risk management processes within the practice to ensure that all risks are assessed and rated with mitigating actions recorded to reduce and manage risks, including those relating to legionella, fire safety, recruitment and electrical testing.
- Update the health and safety policies and procedures used by the practice to ensure that all requirements in the Control of Substances Hazardous to Health Regulations 2002 (COSHH) are met.

Broseley Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Broseley Medical Practice

Broseley Medical Practice is a general practice located in Broseley in Shropshire. It is also a training centre for medical students to gain experience in general practice and family medicine.

The practice has four GPs; one full time male and two male and one female who are part time. There is a practice manager, a nurse practitioner, two practice nurses and a healthcare assistant. They also have a medical secretarial team, a reception team, administrative staff, a mental health counsellor and a care co-ordinator. There are approximately 4600 patients registered with the practice (as at 31 March 2014). The surgery is open from 8:00 am to 1:00pm and 2:00 pm to 6:00 pm Monday to Friday. The practice also provides an evening surgery from 6:30 pm to 8:00 pm every Monday evening to provide easier access for patients who have employment commitments.

The practice treats patients of all ages and provides a range of medical services. Broseley Medical Practice has a large percentage of its practice population in the older age group.

The practice provides a number of services for example reviews for asthma, chronic obstructive disease and diabetes. It also offers child immunisations, contraception advice and travel health vaccines.

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

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

- 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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 October 2014. We spoke with six patients who used the service about their experiences of the care they received. We talked with carers and/or family members and reviewed relevant documents. We reviewed 17 patient comment cards sharing their views and experiences of the practice.

Good

Are services safe?

Our findings

Safe Track Record

The practice had systems in place to identify risks and improve quality in relation to patient safety. For example, national patient safety alerts and comments and complaints received from patients. Staff told us

they were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed records and minutes of meetings where these were discussed. This showed the practice had managed these consistently and so could evidence a safe track record over a previous twelve month period.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. We saw that the practice had very few significant events recorded. We discussed this with the practice manager and the lead GP. They confirmed that this system would be reviewed to ensure that all events that were critical (whether beneficial or detrimental to the outcome) would be included to improve the quality of patient care from the lessons learnt. The GPs at the practice held a weekly meeting and they confirmed that urgent significant events were discussed at these if needed. There was evidence that appropriate learning had taken place from an investigation of each significant event and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues and felt encouraged to do so.

National patient safety alerts were received by all clinical staff at the practice. Staff we spoke with were able to give examples of alerts relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all were aware of those relevant to the practice and where action was needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults including a GP who was their lead in safeguarding vulnerable adults and children. Training records made available to us showed that all staff had received relevant role specific training on safeguarding. We saw that all staff had undertaken training in safeguarding vulnerable adults and the lead GP and nurse practitioner had been trained to advanced level 3 in safeguarding children. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. All staff we spoke with were aware of who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example if a patient was also a carer or had a learning disability. The system enabled the identification and follow up of children, young people and families who were living in disadvantaged circumstances. This included children in need and children on a protection plan and the review of repeat medications for patients with multiple health needs.

We found that GPs used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and liaised with partner agencies such as social services.

A chaperone policy was in place and on display in the waiting area of the practice and each clinical room. We saw that chaperone training had been undertaken by all designated staff. Staff we spoke with understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination appropriately.

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

Good

Are services safe?

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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

We saw records that detailed the actions taken in response to reviews of prescribing data. For example, the patterns of antibiotic prescribing. We saw that the practice was performing well in relation to the number and type of non-steroidal anti-inflammatory prescribing within the practice. We saw that the practice worked closely with the community pharmacist. Any changes to prescribing guidance received by the Clinical Commissioning Group (CCG) medicines management team was shared amongst the GPs. We saw an example of this in respect of a type of medicine used for nausea.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of these directions and evidence that nurses had received appropriate training to administer vaccines.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice limited the number of staff members who generated prescriptions to reduce the possibility of error. We saw that the prescription administrators were located away from reception and reception duties to enable them to have fewer distractions.

Cleanliness & Infection Control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy for staff. We saw evidence where infection control training had been carried out by staff. We saw that an infection control audit had been completed by the lead for infection prevention and control at the CCG. We saw that there were minor areas for improvement identified. The practice manager confirmed that action had already begun to address these areas.

An infection control policy was available for staff to refer to which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy.

Hand hygiene techniques signs were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Staff at the practice carried out regular checks of the water system which were seen recorded. We did not see evidence of a legionella risk assessment to ensure all areas of potential risk were identified with mitigating actions in place.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment logs and other records that confirmed this. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer which was carried out annually by the local hospital maintenance team.

Good

Are services safe?

Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at two staff records and saw that the recruitment policy had not been fully implemented. We saw that some recruitment checks had been undertaken prior to employment for the two staff members. For example, proof of identification. We did not see written references for the staff. We saw that one of the staff members had had a criminal records check carried out via the Disclosure and Barring Service (DBS). The practice manager confirmed that a DBS check was not required for the other staff member due to the nature of the duties carried out by them. We did not see a risk assessment in place for this person to explain why this decision had been made. We saw that all of the nursing staff had had a DBS check. The practice manager confirmed that a review would be carried out to ensure all staff who worked at the practice would either have a DBS check or a risk assessment to show why a DBS was not needed.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave when required.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included monthly checks of the building, staffing, dealing with emergencies, and equipment. The practice had a health and safety policy and the practice manager was the identified health and safety representative.

We saw that some identified risks were recorded and discussed with staff. However we did not see any health and safety risk assessments completed at the practice. Staff confirmed that risks were discussed at practice meetings and within team meetings. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date.

A business continuity plan was in place to deal with a range of emergencies that could impact on the daily operation of the practice. Each risk was identified and actions recorded to reduce and manage the risk. Risks identified included power failure and adverse weather conditions. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

Good

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 treatment approaches. They were familiar with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw evidence of new guidelines being shared amongst the team and the implications for patient care were discussed. One example we saw showed that the NICE guidelines had not been strictly adhered to, however the reasons for deviating from this were given and the patient was seen to be highly satisfied with the treatment. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the lead GP and the nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

The GPs had lead responsibility in specialist areas such as diabetes, asthma, palliative care, dementia and mental health. The practice nurses supported this work which allowed the practice to focus on specific conditions. We saw that a GP and a practice nurse were trained specifically in the treatment of diabetes. This helped to improve the service offered for those patients when invited for their annual health checks.

National data showed the practice was in line with referral rates to secondary and other community care services. Staff told us that they had a record of contributing to and adopting referral pathways to improve the care of the patients and to refer appropriately. An example of this was where the practice offered joint injections for patients at the surgery. The lead GP we spoke with used national standards for referring patients with suspected cancers in order for them to be seen within two weeks.

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

Management, monitoring and improving outcomes for people

We looked at two clinical audits that had been undertaken in the last twelve months. We saw the practice was able to demonstrate the changes since the initial audit for example, the practice had received an alert about a drug safety issue. We saw that appropriate action was taken. Relevant patients' medicines were changed and computer records were updated. We saw that there was good communication with patients about the change and evidence that the prescribing activity was in line with current guidelines.

The GP 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). The QOF rewards practices for providing quality care and helps fund further improvements. The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example all patients with a learning disability who used the practice had received an annual review. The practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

We saw that the practice performed minor surgery and long acting contraceptive implant insertion. We saw that an annual audit of all patients receiving the service was returned to the local CCG and accrediting body in line with national requirements.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as safeguarding children and vulnerable adults.

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

All GPs were up to date with their yearly continuing professional development (CPD) requirements and all had either been revalidated or had a date set for their revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified training and development needs. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example basic life support. Staff spoke positively about working at the practice and how they felt supported to raise any issues or concerns.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and cervical smears. Those with extended roles for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We were provided with a number of examples where the practice worked well with other services. For example, during the inspection we spoke with a mental health worker who had professional knowledge of working with the practice, although was not employed by them. This individual described positive support that practice staff had provided. They gave us an example of when practice staff had stayed beyond their working hours to offer emotional support to a patient with emotional difficulties. This demonstrated a positive and caring approach and a culture to meet the individual needs of the patients.

We also found the practice was proactive in developing and maintaining partnerships with a number of community organisations and other health professionals. For example the practice enabled the Citizens Advice Bureau to use a room at the practice to support patients who may need additional support and advice. The practice employed its own counsellor to support patients with mental health problems such as depression or stress and anxiety. The lead GP confirmed that the waiting times for patients to see the counsellor were extremely favourably and enabled the practice to offer access for patients to professional counselling. The practice also had access to and support from the local community mental health team and Improving Access to Psychological Services (IAPT).

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients, for example, those with end of life care needs. These meetings were attended by GPs, district nurses and palliative care nurses. Decisions made at these meetings about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used an electronic system to make referrals and to communicate with other providers. For example, there was a shared system with the local out of hours

Good

Are services effective?

(for example, treatment is effective)

provider to enable patient data to be shared in a secure and timely manner. The practice made referrals through the Referral Assessment Service and the Choose and Book system in discussion with the patient. (The Referral Assessment Service and Choose and Book enable patients to choose the services and appointments appropriate to their condition).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospitals, to be saved in the system for future reference.

Consent to care and treatment

We saw that the practice had a consent policy and mechanisms to seek and record consent decisions were in place. We saw that the process for obtaining written consent for minor surgical procedures was being strengthened to confirm that the need for the surgery and the risks involved were clearly documented and explained to patients.

The clinicians we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment and are capable of understanding the implications of the proposed treatment and any risks.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. The clinicians we spoke with confirmed that they used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, providing patients with relevant information such as healthy heart leaflets.

The practice had numerous ways to identify patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. Similar mechanisms were in place to identify at risk groups such as patients who were likely to be admitted to hospital and those patients receiving end of life care. These patient groups were offered further support in line with their needs.

The practice also had a member of staff in a temporary post of care co-ordinator who was funded by the Clinical Commissioning Group (CCG). Their role was to support patients by signposting them to appropriate services on referral from the GPs at the practice.

There was a policy to send reminder letters to patients who did not attend for follow up appointments, for diabetes reviews for example. We saw that the practice audited patients who did not attend for annual checks and had a number of ways to follow up patients who had missed their appointments. This included patients who were listed on the mental health register whose mental health might play a part in them missing appointments.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for most immunisations was in line with other practices within the local area and there was a clear protocol for designated staff to follow up patients who did not attend.

Up to date care plans were in place that were shared with other providers such as the out of hours provider and with multidisciplinary case management teams. Patients aged 75 or over and patients with long term conditions were provided with a named GP.

We saw evidence of multidisciplinary meetings which took place every three months to discuss patients who were receiving end of life care. These meetings included palliative care nurses and district nurses as well as practice clinicians.

For emergency patients, the practice had signed up to the electronic Summary Care Record. Summary Care Records

Good

Are services effective?

(for example, treatment is effective)

provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. Information for patients about this was available in the practice waiting area together with a form to enable patients to opt-out from having a Summary Care Record if they chose.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 247 patients undertaken by the practice's Patient Participation Group (PPG). The evidence from these sources showed patients were extremely satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also well above average the Clinical Commissioning Group (CCG) regional average for its satisfaction scores on consultations with doctors and nurses. The survey showed that 89% of practice respondents said the GP was good at listening to them and 86% said the GP gave them enough time. These figures were slightly below the CCG regional average, however 91% would recommend this surgery to someone new to the area.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 17 completed cards and all of the feedback was overwhelmingly positive about the service experienced. Four patients told us that they felt the practice offered a first class service and all patients said that staff were kind, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. We saw this system in operation during our inspection and noted that it was effective in maintaining confidentiality. Patients we spoke with told us that although the waiting area was quite small, the staff were always careful to respect their privacy.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients were generally satisfied about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 74% of practice respondents said the GP involved them in care decisions and 83% felt the GP was good at explaining treatment and results. Both of these results were slightly below the CCG's regional average, however 90% described their overall experience of this surgery as good.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them. They told us that they felt involved in decision making about the care and treatment they received. They also told us that 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 highly positive and aligned with these views.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a multidisciplinary team (MDT) approach with district nurses and palliative care nurses. We saw that the Gold Standard Framework (GSF) palliative care meetings were held and recorded. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients receive supportive and dignified end of life care, where they choose.

Good

Are services caring?

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. Patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

We saw that there were notices in the patient waiting room, on the TV system and patient website which signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown written information which was available for carers to ensure they understood the various avenues of support available to them. Staff told us that special efforts were made to accommodate carers, for example with appointments and flu jabs, and signposted them to carers groups.

The practice had a member of staff in a temporary post of care co-ordinator who was funded by the Clinical Commissioning Group (CCG). Their role was to support patients by signposting them to appropriate services on referral from the GPs at the practice. For example, families who had suffered bereavement were signposted to support organisations like CRUSE bereavement care or Age UK, both national charities. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to 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.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed. We saw that actions had been agreed to implement service improvements and manage delivery challenges to its population. For example the high number of attendances at the hospital accident and emergency department. The GP we spoke with confirmed that a recent meeting with the CCG to discuss emergency admissions to hospital had demonstrated a fall in numbers.

We saw there was a system in place that ensured patients with long term conditions such as asthma and diabetes received regular health reviews in one of the specialist nurse led chronic disease clinics at the practice. Clinical staff told us they carried out regular and routine blood tests for patients with diabetes. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions.

The practice had implemented suggestions for improvements and made changes as a consequence of feedback from the Patient Participation Group (PPG). Some examples of this included, new seating in the waiting area specifically for patients with mobility issues and a new web media screen to provide patients with relevant information. The entrance door to the practice had been updated and was automated to improve access into the building. This was particularly beneficial for patients who used a wheelchair and families with pushchairs. This was carried out as a result of patient feedback from a recent survey and from parents who attended the baby clinic.

The practice had achieved and implemented the Gold Standards Framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families care and support needs.

The practice had a rolling programme of patients between 40 and 74 years of age to invite them for NHS health screening checks and provided a cervical screening programme. Shingles vaccinations were available for people aged 70 or 79. Clinics for childhood immunisations were held and six week checks were carried out for babies.

We saw that the PPG had organised a dementia awareness event in September 2014 to help people, particularly carers, understand how to care for and respond to people with dementia. This event was supported by the practice, the CCG and Shropshire Council and various charities and organisations such as the Alzheimer's Society, Shropshire Dementia Action Society and a specialist home care provider.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. For example with palliative care co-ordinators, district nurses and the community mental health team.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. For example those with a learning disability and carers. The practice provided longer appointments for these patients when required.

There was one female GP who worked part time at the practice was able to support patients who preferred to have a female doctor. This reduced any barriers to care and supported the equality and diverse needs of the patients.

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a disabled toilet and wheelchair access to the practice for patients with mobility difficulties. Most treatment and consulting rooms for patients were located on the ground floor. We saw that one consultation room was situated on the first floor. Staff told us that patients who had mobility difficulties would always be seen on the ground floor.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Comprehensive information about appointments was available to patients 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 in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Appointments were available from 8:00 am to 1:00 pm and 2:00 pm to 6:00 pm on weekdays. Late night appointments were provided one evening per week from 6:30 pm to 8:45 pm to provide an opportunity for working patients to have an appointment around their work commitments. The practice had an online booking system which patients told us was easy to use. There were also telephone consultations for patients where appropriate.

Patients were extremely satisfied with the appointments system. Comments received from patients showed that those in urgent need of treatment had been able to make appointments on the same day of contacting the practice. The national GP survey for 2013 showed that 93% of respondents found it easy to get through to the practice by phone and 84% of respondents usually waited 15 minutes or less after their appointment time to be seen. This was above the CCG regional average of 66%. The survey also showed that 97% of respondents said that the last appointment they got was convenient which was also above the CCG regional average of 94%.

The patient participation group (PPG) at the practice carried out an annual survey. For 2014 the PPG had designed and carried out a satisfaction survey which included questions about access to appointments for the service. We saw that 247 completed surveys were returned. The survey showed that 78% of those who responded said that when they asked for an appointment to be seen the same day, they were given an appointment or received a phone call from the doctor or Nurse that day. Other feedback from the survey showed that 54% of respondents were not aware of the weekly extended opening hours service for patients in full time employment. We saw that an action plan had been put into place to improve these figures.

We saw that the waiting area was able to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

We saw that one of the GPs was the lead for managing complaints. Information was provided to help patients understand the complaints system. For example a complaints leaflet was available in the waiting area and details about how to make a complaint were set out on the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice but knew that they could make a complaint on-line or by a feedback box in the waiting room.

There were only two complaints received since 1 April 2014 and we found each was handled in a satisfactory and timely manner. Due to the low number of complaints recorded from patients, we discussed the different types of concerns and grumbles received by the practice on a day to day basis. The practice manager confirmed that most issues were dealt with immediately, however these needed to be recorded in order to demonstrate the proactive response to and resolution of the patient's concern. We saw that due to the low number of complaints, there was not an annual review of complaints carried out to detect themes or trends. We discussed this with the practice manager who told us that all types of complaints would be recorded and an annual review would be carried out to ensure any areas of weakness were identified and addressed.

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 mission statement which set out its aims and objectives including "to provide a high standard of medical care" and "to be committed to our patients needs". We spoke with the practice manager about the practice's values and they confirmed that these were discussed at induction, at meetings with staff and during appraisals. We spoke with six members of staff and they all knew or demonstrated the values of the practice and what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and staff told us these were easily accessible to them. We looked at these policies and procedures and saw that they had been reviewed and were up to date.

The practice held regular practice meetings where all areas of governance were considered. We looked at minutes from the previous two meetings and found that performance and quality had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF rewards practices for providing quality care and helps fund further improvements. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and action taken to maintain or improve outcomes.

The practice had completed a number of clinical audits, for example a diabetic audit. We evidence of how the practice tailored treatment to meet the needs of the patients following the audit. The audit showed patients were highly satisfied with the treatment changes.

The practice had arrangements for identifying, recording and managing risks, for example we saw evidence that the fire safety risk assessment and portable equipment testing had been completed.

Leadership, openness and transparency

We saw that there was a leadership structure which had named members of staff in lead roles. For example one GP was the lead for safeguarding children and vulnerable adults and another was the lead for complaints. We spoke with five members of staff and they were all clear about their own roles and responsibilities. Staff told us that they all worked as part of a team and supported each other.

The practice held a number of meetings which were minuted. These included practice meetings, clinical meetings, staff meetings, meetings with other professionals such as a frail and elderly meeting and a meeting to discuss vulnerable families with the health visitor. We saw that some of the staff team meetings were informal. The practice manager confirmed that these needed to be more formalised and plans were in place for this to happen. Staff told us that the meetings were useful and they felt well informed. Staff told us that there was an open culture within the practice and they had the opportunity and felt able to raise issues at any time with the partners and practice manager.

The practice manager had overall responsibility for the human resource policies and procedures. We reviewed a number of policies, for example a recruitment and induction policy which was in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice gathered feedback from patients through patient surveys, suggestion box comments and complaints received. We looked at patient surveys and complaints made by the patients. We saw that positive action had been taken in response to these. For example the front doors of the practice had been replaced to improve access into the building, particularly for patients who used a wheelchair and mothers with pushchairs. This was carried out as a result of patient feedback.

The practice had an active patient participation group (PPG) which met every four to six weeks and was supported by the practice manager. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. The chair of the PPG told us that the group had been trying to recruit members from all age groups and backgrounds in order for them to be representative of the practice population. Information about the patient participation group was provided on the practice's website and patients were encouraged to join the group.

Are services well-led?

Good

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

We saw that the PPG at the practice carried out an annual satisfaction survey for patients with support from the practice. The survey was distributed by several members of the patient group to all patients calling into the practice over a number of days in order to reach a representative spread of practice users and to encourage a high response rate. We saw that the results of the most recent surveys were available on the practice website.

The practice had gathered feedback from staff through meetings, appraisals and discussions. The practice had a whistle blowing policy although staff were unsure where to access this. However staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff records and saw that annual appraisals took place which included identified training and development needs. Staff told us that the practice was very supportive of training. Records we checked showed that a range of training had been completed by staff which included safeguarding for children and vulnerable adults, and infection control.

The practice was a training practice for medical students. We spoke with one of the medical students who confirmed that they had extended appointment times with patients and received ongoing clinical support from the lead GP.

The practice had completed reviews of significant events and other incidents and shared them with staff at meetings to ensure the practice improved outcomes for patients. For example, there was an incident where there was a prescribing error. This led to a change in policy and an alert was put onto the patient's record for an early review. We saw that this serious incident was handled well by the staff and discussed at a staff meeting.