Cleobury Mortimer Medical Centre

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 carried out an announced comprehensive inspection at Cleobury Mortimer Medical Centre on 14 April 2016. Overall the practice is rated as good and rated outstanding in providing services for patients with long-term conditions.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The practice had a clear vision on working in partnership for better health and wellbeing which underpinned commitment to good patient care and safety. Patient feedback and survey data, secondary care data and information from organisations such as the care coordinator and compassionate community (Co Co) staff member evidenced the effectiveness of this approach. (The Co Co initiative is not run by any one organisation but the community itself with the support of a hospice which provided training and ongoing guidance for volunteers. The scheme involves working with a number of local communities and medical practices).
- Feedback from patients about their care was consistently positive. The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- The practice nurse with a specialism in diabetes also provided home visits to housebound patients, and the practice provided the diabetes medicine, insulin, and initiation treatment in-house.
- The practice used innovative and proactive methods to improve patient outcomes and worked with other

Summary of findings

local providers to share best practice. For example, glucose levels were checked for patients who had an NHS health check or review of long term conditions. Further investigations took place if glucose levels were elevated. Patients who were identified as in the pre-diabetic range were given lifestyle advice and monitored annually.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.
- Patients said they found it easy to make an appointment, patients with a named GP or preferred to see a specific GP saw them within a reasonable period of time, there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities within a modern building and was well equipped to treat patients and meet their needs.

We saw an area of outstanding practice:

One of the GP partners provided an in house service for rheumatology patients registered at the practice. They provided a full range of joint injections and monitoring of medication, decreasing the need for hospital appointments. This prevented unnecessary travel for patients who may ordinarily travel to Kidderminster or Shropshire for investigations, treatment and consultations.

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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- Local and national data and our observations corroborated that these guidelines were positively influencing and improving practice and outcomes for patients. For example, 98% of diabetic patients had had an influenza vaccination within the preceding 12 months compared with a national average of 94%; the percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months, was 94% which was better than the national average of 75%. The percentage of patients with Chronic Obstructive Pulmonary Disease (COPD), who had a review undertaken including an assessment of breathlessness in the preceding 12 months, was 97%, which was better than the national average of, 90%.
- Data showed that the practice was performing highly within the Clinical Commissioning Group (CCG). For example, data showed the practice was performing well in reducing attendance at accident and emergency and hospital admissions. The practice provided consultations for minor injuries in order to keep A&E attendances low; they had demonstrated in 2014/15 the A&E emergency admission rate was 11% compared to the national average of 14%.

Summary of findings

- The practice provided an on-site diagnostic service for anti-coagulation where blood is monitored on the premises and did not have to be sent to a laboratory for testing. This provided a quick and easy local service for patients including any change of medicine dosages.
- The practice diabetic clinics included the initiation of a particular medicine; insulin, used in the treatment of diabetes, provided by suitably skilled and qualified clinical staff.
- The practice used innovative and proactive methods to improve patient outcomes and worked with other local providers to share best practice. For example, glucose levels were checked for patients who had an NHS health check, or review of long term conditions. Further investigations took place if glucose levels were elevated. Patients who were identified as in the pre-diabetic range were given lifestyle advice and monitored annually.
- A range of quality clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff and the practice had a culture of continuous shared learning.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey 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 decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice identified frail and vulnerable patients and were appropriate referred patients to the local Compassionate Communities (Co co) service who offer a befriending service and regular visits to give extra non personal care support when required.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of the local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- The practice had shared care arrangements in place for patients with substance misuse with an in-house service from the community Drug and Alcohol Action Team (DAAT).
- The practice nurse with a specialism in diabetes provided home visits to housebound patients.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice website provided vital information to patients such as providing information on the community car scheme service which was run on a volunteer basis mainly for appointments at the practice and Hospitals but also opticians.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken

Summary of findings

- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, all over 75's had a named GP
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The frailest two per cent of the practice patients had in place an admission avoidance care plan which highlighted their needs and wishes and was reviewed regularly. All admissions of patients on this plan were discussed to see if they were avoidable.
- The practice provided services to two care homes (46 patients in total) and a named doctor visited the care homes on an at least weekly basis. Patients in care homes had a Care Home Advanced Scheme (CHAS) plan and the clinical staff analyse admissions and any deaths in these groups in order to maintain high standards of care.
- The practice worked closely with the local Community Care Coordinator who was a valued member of the practice team, and who worked with the GPs and district nurses to achieve personal care for patients who wished to retain independence and remain in their own homes.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

- The practice provided an on-site diagnostic service for anti-coagulation where blood was monitored on the premises and did not have to be sent way to a laboratory for testing. This provided a quick, accurate and easy local service for patients, saving patients a journey to hospital.
- The practice diabetic clinics included the initiation of a particular medicine used in the treatment of diabetes, insulin, by skilled and qualified clinical staff. The practice diabetes nurse provided home visits to housebound patients.
- One of the GP partner's provided an in house services for rheumatology patients registered at the practice. They provided a full range of joint injections and monitoring of medication, decreasing the need for hospital appointments.This prevented unnecessary travel for patients who may otherwise have had to travel to Kidderminster or Shropshire.
- Each doctor had individual responsibility for specific clinical areas, to maintain high standards and high QOF achievement. The practice maintained registers for long term conditions they monitored their work according to clinical guidelines to standardise care. For example, of the 109 patients with Chronic Obstructive Pulmonary Disease (COPD) 104 had a treatment/ care plan in place, (95). (COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema).
- 84% of patients on repeat medicines had had a medication review in the past year and 94% of patients on four or more medicines had had a polypharmacy review by a community pharmacist.
- The frailest 2% of the practice patients had in place an admission avoidance care plan which included many patients with long-term conditions. The practice had systems in place to "flag" patients with chronic or life limiting conditions to the out-of-hours service and provide information to enable continuity 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- The practice held regular clinical meetings, attended by health visitors, where children at risk, child welfare concerns and

safeguarding issues were discussed to ensure awareness and vigilance. The practice had a system in place to highlight patients of concern, as well as those who were considered at risk and both patient registers were discussed at clinical multi-disciplinary meetings. The practice worked with the local primary school to ensure a complete register.

- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Quality and Outcomes Framework (QOF) data from 2014/15 showed that the percentage of women aged 25-64 whose notes record that a cervical screening test had been performed in the preceding 5 years was 81.04%, which was comparable to the national average of 81.83%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice accessed "CHOICES" a charity dealing with pregnancy related issues, who used the practice premises for pregnancy counselling and the practice could refer to the teenage pregnancy advisor.
- The practice offered a full range of contraceptive services.

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 reflects the needs for this age group.
- The practice provided an extended hours service each Thursday from 7am.
- The practices saw students who were at home from university as temporary residents.
- The practice provided NHS health checks to the over 40s.
- The practice provided consultations for minor injuries in order to keep A&E attendances low; they had demonstrated in 2014/15 the A&E emergency admission rate for 19 ambulatory care sensitive conditions was 10.77% when compared to the national average of 14.6%.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice frail and vulnerable register also included carers.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice maintained a learning disability register and ensured that individuals received appropriate services from the practice to meet their needs which included, involvement where required in care planning, treatment and support.
- The practice had shared care arrangements in place for patients with substance misuse with an in-house service from the community Drug and Alcohol Action Team (DAAT).
- All patients on the practice palliative care register were reviewed at a multidisciplinary monthly meetings attended by GPs, practice nurses, district nurses and a Macmillan nurse.

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).

- 79%
- Quality and Outcomes Framework (QOF) data from 2014/15 showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 87.5% which was comparable to the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice maintained a register of patients registered at the practice experiencing poor mental health and each had a care plan in place which was reviewed and monitored as appropriate with the practice and specialist community teams. For example, 79% of those recorded on the mental health register had a care plan. A regular search was performed for patients on antidepressant medicines who had not attended their review appointment and efforts were made to contact these patients.
- The practice associated service “Compassionate Communities” (Co co) staff member had run a dementia awareness session for carers which was well received and a second one was planned.
- Clinical staff had received training in the Mental Capacity Act and used this when assessing appropriate patients.

Summary of findings

What people who use the service say

The national GP patient survey results were published January 2016. The results showed the practice was performing better than local and national averages. Two hundred and forty-three survey forms were distributed and 128 were returned, a 53% response rate. This represented approx. 2% of patients on the practice's patient list.

- 98% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 88% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 98% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 95% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local CCG average of 84% and national average of 78%.

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 15 comment cards which were all positive about the standard of care received. Patient's comments included that staff were helpful, friendly, respectful, professional, attentive, courteous and willing to go the extra mile.

We spoke with three patients during the inspection. All patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Outstanding practice

One of the GP partners provided an in house service for rheumatology patients registered at the practice. They provided a full range of joint injections and monitoring of medication, decreasing the need for hospital appointments. This prevented unnecessary travel for patients who may ordinarily travel to Kidderminster or Shropshire for investigations, treatment and consultations.

Cleobury Mortimer Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Cleobury Mortimer Medical Centre

Cleobury Mortimer Medical Centre is located in Cleobury Mortimer, Shrewsbury, Shropshire. It is part of the NHS Shropshire Clinical Commissioning Group. The total practice patient population is 7, 136. The practice has a higher proportion of patients aged 65 years and when compared with the practice average across England. For example, the percentage of patients aged 65 and above at the practice is 26%; the local CCG practice average is 24% and the national practice average, 17%.

The staff team comprises of four GP partners, and a former partner GP who provides regular sessions when required, and two GP registrars. Of the four GP partners, two work eight sessions per week and in total the practice provides 3.5 whole time equivalent GPs, plus GP registrar sessions. The clinical practice team includes three practice nurses and a healthcare assistant. The practice is managed and supported by a full time practice manager, an assistant business manager, an office manager, eight reception staff and a secretary. In total there are 21 full or part time staff employed.

The practice is open Monday to Friday 8.30am to 6pm (excluding bank holidays). The practice provides an extended hours service each Thursday morning from 7am. In addition the practice offers pre-bookable appointments. Urgent appointments are also available for patients that need them. 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 through Shropdoc, the out-of-hours service provider. The practice telephones switches to the out-of-hours service at 6pm each weekday evening and during weekends and bank holidays.

The practice provides long-term condition management including asthma and diabetes. It also offers child immunisations, minor surgery and travel vaccinations. The practice offers NHS health checks and smoking cessation advice and support. The practice has a Personal Medical Services (PMS) contract with NHS England. This is a contract for the practice to deliver Personal Medical Services to the local community or communities. They also provide a number of Directed Enhanced Services, for example they offer extended hours access, minor surgery and the childhood vaccinations and immunisation scheme.

The practice is a teaching and training practice and have been training medical students and doctors for over 30 years. The doctors and students follow a training schedule and are continually monitored and assessed by their University and the Deanery to which they belong.

Detailed findings

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. The 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.

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 were provided for specific groups of people and what good care looked 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 visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 14 April 2016. During our visit we spoke with a range of staff which included the practice manager,

nursing staff, administrative/ receptionist staff and GPs. We spoke with three members of the patient participation group. We reviewed 15 comment cards where patients shared their views and experiences of the service.

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw that lessons were shared and action was taken to improve safety in the practice. There had been 20 recorded incidents/events in the past 12 months and from 2002 onwards there had been regular recording and actioning of events. Of the 20 events, five were prescribing errors, five were clinical and the remainder a mix of administrative, reception or communication. We saw that the practice reviewed their records and no trends were identified. All were concisely recorded, documented and the actions, learning, and people responsible were clearly stated. For example, a safeguarding issue had been picked up by staff which had led to appropriate actions taken by the practice and the safeguarding team.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and practice nurses were trained to an appropriate level to manage child protection or child safeguarding.
- The practice had a system in place to highlight patients of concern, as well as those who were considered at risk and both patient registers were discussed at clinical multi-disciplinary meetings. The practice worked with the local primary school to ensure a complete register.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been

adopted by the practice to allow nurses to administer medicines in line with legislation. The healthcare assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. The practice manager assured us that the staff who attended the drills would be listed in the future to be certain that all staff had attended a regular fire drill. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The practice was proactive in using the electronic patient record for alerts and diary entries, which ensured effective, proactive care and regular reviews.
- The practice provided an on-site diagnostic service for anti-coagulation where blood is monitored on the premises and did not have to be sent way to a laboratory for testing.This provided a quick, accurate and easy local service for patients.
- The practice diabetic clinics included the initiation of a particular medicine, insulin, used in the treatment of diabetes, provided by suitably skilled and qualified clinical staff. The practice nurse with a specialism in diabetes provided home visits to housebound patients.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 95% of the total number of points available. The clinical exception reporting average overall was 6%, this was 3% below the Clinical Commissioning Group (CCG) average and 3% below the national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

The frailest two per cent of the practice patients had in place an admission avoidance care plan which highlighted their needs and wishes and was reviewed regularly. All admissions of patients on this plan were discussed to see if they were avoidable.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months, was 94% which was better than the national average of 75%.
- The percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who had a review undertaken including an assessment of breathlessness in the preceding 12 months was 97%, which was better than the national average of, 90%.
- The percentage of patients with atrial fibrillation (AF) with CHADS2 score of 1, who were treated with anticoagulation therapy or an antiplatelet therapy, was 100% which was slightly better than the national average of 99%. (The CHADS2 score is a clinical prediction rule for estimating the risk of stroke in patients with non-rheumatic atrial fibrillation which is a common and serious heart rhythm condition).
- Performance for diabetes related indicators were similar to the national average; however the clinical exception reporting for this indicator was 6%, which was lower than the CCG average of 11% and the national average of 11%. The practice nurse with a specialism in diabetes also provided home visits to housebound patients and the practice provided the diabetes medicine, insulin, and initiation treatment in-house.
- The percentage of patients with hypertension having regular blood pressure tests was 86% which was slightly better than the national average of 84%.
- Performance in four mental health related indicators were in line with the national average. However the clinical exception reporting for this indicator was 8%, which was lower than the CCG average of 10%, and the national average of 11%. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their record was 88% which was the same as the national average.
- Data showed that the practice was performing highly within the Clinical Commissioning Group (CCG). For

example, data also showed the practice was performing well in reducing attendance at accident and emergency and hospital admissions. The practice provided consultations for minor injuries in order to keep A&E attendances low; they had demonstrated in 2014/15 the A&E emergency admission rate was 11% compared to the national average of 15%.

Each GP had individual responsibility for specific clinical areas, to maintain high standards and high QOF achievement. The practice maintained registers for long-term conditions and they monitored their work according to clinical guidelines to standardise care. For example, at the time of our inspection, on the practice registers; of the 109 patients with Chronic Obstructive Pulmonary Disease (COPD), 104 patients had a treatment/care plan in place, (95%). (COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema). Of the practices' 471 asthma patients, 364 patients had a treatment/care plan in place, (77%) at the time of our inspection.

We saw that 84% of patients on repeat medicines had received a medication review in the past year and 94% of patients on four or more medicines had had a polypharmacy review by a community pharmacist.

There had been a wide range of clinical audits completed in the last two years. Three of these (chronic kidney disease management audits, cholesterol results, and combined oral contraceptive prescribing audits) were completed audits where the improvements made were implemented and monitored and re-audited. Evidence was seen of regular clinical audits were being used to assess, improve and monitor performance going back to at least 2010.

- Findings from the two cycle audit on the appropriate coding, management and monitoring of Chronic Kidney Disease (CKD), showed an improvement in detection and diagnosis between the two cycles (from 3% to 5%), improved specific blood test monitoring (73% to 97%) and highlighted the need to improve blood pressure control for CKD patients. (The audit showed obvious benefits to patient care.)
- The practice used complaints and significant events to trigger audits, and was reflective in assessing where care could be improved. For example they had completed an audit in paracetamol medicines and produced a patient leaflet on medicines that contain paracetamol following their audit to reduce the risk of accidental overdose.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, practice patients were assessed and recruited into trials/research through the West Midlands Clinical Research Network, the results of which were shared with the practice and patients.
- One of the GP partners provided an in house service for rheumatology patients registered at the practice. They provided a full range of joint injections and monitoring of medication, decreasing the need for hospital appointments. This prevented unnecessary travel for patients who may ordinarily travel to Kidderminster or Shropshire for investigations, treatment and consultations. In 2015, only 80% of the 52 patients referred directly for a Magnetic Resonance Imaging scan (MRI) of the knee by the GP running the clinics needed onward referral to an orthopaedic specialist. The other 20% (10 patients) were dealt with in-house. Before the in-house service began, 100% of patients requiring such investigations would have required referral to an orthopaedic specialist first. The in-house service has provided a very cost-effective and patient centred way of filtering out unnecessary referrals to secondary care. (An MRI scan is a medical investigation tool that uses an exceptionally strong magnet and radio frequency waves to generate an image of areas of the body).
- The practice accessed "CHOICES" a charity dealing with pregnancy related issues, who used the practice premises for pregnancy counselling and the practice could refer to the teenage pregnancy advisor.
- The cancer incidence and prevalence rate was found to be in line with the patient demographic, with the percentage of patients older than 65 being higher than the national average.

Information about patients' outcomes was used to make improvements such as, the reduction in the prescribing of a specific group of antibiotic medicines, due to their

Good

Are services effective?

(for example, treatment is effective)

association with clostridium difficile infection. Systems were put in place to improve the documentation of the rationale for antibiotics used. The practice planned to reaudit their prescribing figures in a six month period.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. The practice prioritised training and development for the whole team. For example a practice nurse could demonstrate the additional training completed to support patients living with diabetes and to initiate a diabetes medicine, insulin, with the support of the GP partners.
- Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an interim six month review invitation to discuss any changes to their training or development needs and all had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- There was adequate clinical capacity within the practice to meet anticipated demand, including internal cover for holiday leave and other planned absences.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- We saw that referrals for care outside the practice were appropriately prioritised and the practice used approved pathways to do so with letter dictated and prioritised by the referring GP. For example, the two week wait and urgent referrals were sent the same day, and routine referrals were sent within 24 to 36 hrs.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

We saw evidence that multi-disciplinary team meetings took place regularly and that care plans were routinely reviewed and updated where patients' needs had changed. The practice worked with the Care Coordinator and Compassionate Communities to ensure that their patients' health and social care needs were being assessed and met. The Care Coordinator and Compassionate Communities staff member spoke with the inspection team explaining the practice was very effective at working with them to improve outcomes for patients and partner organisation colleagues and gave examples of excellent partnership working to the inspection team.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Clinical staff had also been in receipt of training in the

Good

Are services effective?

(for example, treatment is effective)

Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records. The practice had provided clear information to all patients prior to minor surgery which was documented in the patient's records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation were signposted to the relevant service. The practice ran regular cardiovascular disease clinics in which they offered health promotion advice and exercise on prescription.
- The practice hosted additional services to enable eligible practice patients to be seen by visiting clinical staff at the practice for screening, such as the retinal screening service and abdominal aortic aneurysm (AAA) screening (AAA is an enlarged area in the lower part of the aorta, the major blood vessel that supplies blood to the body).
- The practice provided a full family planning service as well as an emergency contraceptive service.

The practice's uptake for the cervical screening programme was 81%, which was comparable to the national average of 82%. There was a system in place to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example, 74% of females patients aged 50 to 70 years had been screened for breast cancer in last 36 months and 61% of patients aged 60 to 69 years had been screened for bowel cancer in last 30 months. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93% to 98% and five year olds from 92% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. For example, glucose levels were checked for patients who had an NHS health check, where consented to do so, or review of long term conditions to identify early signs of diabetes. Further investigations took place if glucose levels were elevated. Patients who were identified as in the pre-diabetic range were given lifestyle advice and monitored annually.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 15 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. An example of the extra mile staff went to support their patients was noted in one of the comment cards received. They said that the practice provided care and treatment and staff had ensured that their dog was okay whilst they attended their consultation.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was consistently above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 97% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 96% of patients said the GP gave them enough time compared to the CCG average of 92% and the national average of 87%).
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%).
- 96% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%).
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%).
- 96% of patients said they found the receptionists at the practice helpful compared to the CCG average of 91% and the national average of 87%).

The practices national GP survey results were better than the local CCG averages and significantly better than the national averages.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were higher than national averages. For example:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and the national average of 86%.
- 93% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 95% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

Good

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had a frail and vulnerable register which included patients who were carers which had identified 127 patients, 1.8% of the practice list. The register was reviewed, monitored and care and treatment discussed in multi-disciplinary meetings. Carers were also offered NHS Healthchecks. Patients' written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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.

- The practice offered extended hours on a Thursday morning from 7am for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice provided a counselling service and patients had access to appointments at the practice with the Community Mental Health nurse.
- The practice provided a weekly minor surgery clinic.
- A podiatrist service was hosted by the practice.
- The practice had shared care arrangements in place for patients with substance misuse with an in-house service from the community Drug and Alcohol Action Team (DAAT).
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately and were a certified Yellow Fever travel vaccination centre.
- There were disabled facilities, a hearing loop and translation services available.
- The practice provided in house hearing tests.
- The practice had a lift to improve access should patient services be extended onto the first floor of the new building.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services, such as automated doors to the practice entrance reception area. The practice had plenty of parking spaces for patients which included disabled bays and could accommodate easy ambulance access.
- The practice website provided vital information to patients such as providing information on the community car scheme service which was run on a volunteer basis mainly for appointments at the practice and Hospitals but also opticians.
- The practice worked closely with the local Community Care Coordinator and compassionate communities (Co Co) staff member who was a valued member of the practice team, who worked with the GPs and district nurses to achieve personal care for patients who wished to retain independence and remain in their own homes.

Access to the service

The practice was open Monday to Friday between 8.30am to 6pm (excluding bank holidays). The practice provided extended hours service each Thursday morning from 7am. In addition the practice offered pre-bookable appointments. Urgent appointments were also available for patients that needed them. The practice did not provide an out-of-hours service to its own patients but had alternative arrangements for patients to be seen when the practice was closed through Shropdoc, the out-of-hours service provider. The practice telephones switched to the out-of-hours service at 6pm each weekday evening and at weekends and bank holidays.

Results from the national GP patient survey January 2016 showed that patient's satisfaction with how they could access care and treatment was comparable or better than the local and national averages.

- 79% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 78%.
- 98% of patients said they could get through easily to the practice by phone compared to the CCG average of 86% and national average of 73%.
- 63% of patients usually get to see or speak to their preferred GP compared to the national average of 59%.

  87% of patients said they usually waited 15 minutes or less after their appointment time to be seen which was significantly better than the local CCG average of 64%, and national average of 65%.

Evidence was seen which showed how the practice ensured that patients were seen in a timely fashion, and that most patients were seen within 24 hours and the maximum waiting time for a routine appointment, with a

Good

Are services responsive to people's needs?

(for example, to feedback?)

named GP was around seven to eight days. The practice had a system in place to assess whether a home visit was clinically necessary; and the urgency of the need for medical attention.

The GP telephoned the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. Telephone advice by the GP or practice nurse was available when they were not consulting and patients requesting this left their details with the receptionists who asked the doctor or nurse to return the call.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system which included a summary leaflet.

We looked at three complaints and found these were satisfactorily handled and dealt with in a timely way. There was openness and transparency when dealing with the complaint which included the complainants' involvement. Lessons were learnt from individual concerns and complaints and also from the analysis of trends and action was taken as a result, to improve the quality of care. There had been no reported formal or informal complaints since June 2015. The practice had reviewed and discussed this with staff to reaffirm the need to report any informal complaints such as verbal comments as well as formal complaints, there had been no complaints made. Complaints records demonstrated that complaints were recorded and well documented and we saw records which dated back to 2007.

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.

- Although the practice did not display a mission statement, staff knew and understood the practice ethos and values.
- The practice had a robust strategy and supporting business plans which reflected its vision and values and which were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings and we were able to review minutes of the meetings held.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice had received positive feedback from medical students and GP registrars who had been in receipt of training support at the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and compliments and complaints received. The PPG met regularly, had in the past carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had been involved with reviewing information about a Voluntary Car Scheme for patients to access services at the practice where transport was not readily available. The group had 12 regular meeting attendees in their membership and fluctuated at

Are services well-led?

Good

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

around 20 members overall who carried out specific activities as deemed necessary. The agenda items ranged from practice specific topics to discussion on wider issues likely to impact on the practice and its community, as well as involvement with the wider PPG network.

- The three members of the PPG we met said they were proud of the practice's "whole community" approach and were keen to increase both its activities and the diversity of the group to encompass and reflect the community.
- The practice manager regularly attended the PPG meetings and the GPs attended when required. The PPG reported that it would be helpful to have to partners attend more regularly than at present. The partners assured us they would attend where required more regularly. The practice fed back at these meetings on issues and findings such as their recent Health and Safety report carried out by the building management company. For example there had been two areas highlighted, on-road signage at the main gate and unmarked kerbstones which were being actioned. The PPG had fed back to the practice the lack of referrals to the local gym to improve patients' health and well-being and referrals to the service were said to have increased as a result.
- The practice had gathered feedback from staff through staff meetings, appraisals and daily discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and were told by that staff that they could add to the practice meeting agenda and in meetings discuss their thoughts and ideas. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was also part of the West Midlands Clinical Research Network linked mainly with Keele and Oxford Universities.

The practice used innovative and proactive methods to improve patient outcomes and worked with other local providers to share best practice. For example, glucose levels

were checked for patients who had an NHS health check, where consented to do so, or review of long term conditions (except diabetes). Further investigations took place if glucose levels were elevated. Patients who were identified as in the pre-diabetic range were given lifestyle advice and monitored annually.

The practice was insightful about current and potential future challenges and planned toward meetings them; for example, GP and practice nurse recruitment in succession planning, an expanding list size with a new local house building development, patient migration from other practices and population growth.