Brown Clee Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Brown Clee Medical Centre is comprised of two locations - the main practice at Ditton Priors, Bridgnorth, and a branch location in Stottesdon. We carried out an announced comprehensive inspection at Ditton Priors and visited the dispensary at Stottesdon on 10 June 2015. Overall Brown Clee Medical Centre is rated as outstanding.

Specifically, we found the practice to be outstanding in caring and responsive and good for providing safe, effective, and well-led services. It was also outstanding in providing caring and responsive services for older people, families, children and young people and people whose circumstances make them vulnerable.

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure they met patients' needs.
- 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 (PPG).
- 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
- The practice had a clear vision which had quality and safety as its top priority. A business plan and strategy

Summary of findings

was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- 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.

We saw several areas of outstanding practice including:

- The practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced use of accident and emergency facilities and the out-of-hours service, and positive patient survey results.
- The practice had reached out to the local community by supporting people with learning disabilities who attended a local farm and a children's adventure group should the need arise, for minor illness. The practice also supported the local church initiatives, for example in delivering food bank packages.
- The practice funded and facilitated a walking for health group at the local village hall.
- The practice funded physiotherapy, chiropody, a meditation group for mindfulness sessions and a counsellor for its registered population.
- The practice provided weekly comfort visits as well as appointments and home visits to patients residing at three local care homes.
- The practice worked with the local CCG in accepting patients who may be experiencing difficulties in registering with other practices for a variety of reasons, whose circumstances may make them vulnerable.

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

The provider should:

- Complete an Infection and Prevention Control audit.
- Ensure that the practice maintains appropriate recruitment records and introduce systems to verify staff registration with their appropriate professional bodies.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice had not completed a recent infection and prevention control audit. Some staff recruitment records were incomplete.

Are services effective?

Good

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

There were some innovative services in place for health promotion for the patients. The practice provided almost a "one stop shop" for patients to access health and community services. For example, they facilitated Citizens Advice Bureau weekly sessions each Monday for the local registered community. The practice worked very closely with other health professionals and community and voluntary services and they were focused on using every opportunity for health promotion. For example, the practice offered a wide range of additional services for example, physiotherapy, chiropody, foot health screening, minor surgery, counselling, dietician, a walking/ exercise group, and a meditation group. The practice offered electrocardiogram (ECG) testing, (this records the electrical activity of the heart to detect abnormal rhythms and the cause of chest pain). The practice provided diabetic foot screening along with aortic aneurysm screening (a swelling of a major artery called the aorta) to the local area at the practice branch location. A wide range of information was available for patients in the practice and on the web site.

Summary of findings

Are services caring?

Outstanding 

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

The practice supported its local community. Examples included; funding a walking/exercise for health group, the lead GP provided a mindfulness mediation group; the practice registered and had awareness of the support needs of young and older carers. The practice supported the local church in delivering food bank packages.

The practice provided a counsellor, physiotherapist, dietician, chiropodist, and minor illness support to its registered patients. They also provided a minor illness service for people with learning disabilities not registered at the practice who attended a local farm and to a local children's adventure group.

The practice had written a document for residential care home patients relatives regarding what to expect with end-stage dementia and also provided information on the support available. The three care homes the practice visited told us the GPs provided a responsive service above and beyond their expectations and visited patients after the practice was closed to provide comfort visits when required.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Summary of findings

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. For example the practice was engaged in the successful bid for the Prime Minister's Challenge Fund and was one of the 36 practices selected. The practice had involved the PPG in its five to 15 year business and development strategy. The PPG met with the practice, NHS England and the CCG and was fully informed of its involvement with the Prime Minister's Challenge fund. The PPG was also an active participant in the development of the practice mission statement. The PPG gave numerous examples of how the practice responded to patients' needs. These included; the practice opening times, gaining a same day appointment for non-urgent appointments on almost all occasions, the availability of a dispensary at both its locations, a local physiotherapist, dietician, counsellor and a chiropodist. The local nursing and care homes informed us the practice provided comfort calls of an evening between 6.30-7.30pm for patients who required support as well as the GP service they provided. They described the practice staff as responsive to patients' needs, supportive and compassionate.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on the same day. One hundred per cent of respondents to the national GP survey published in January 2015 said they could get through easily to the surgery by phone which was higher than both the local CCG and the national average. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice had clear awareness of workforce succession planning and was one of the 36 practices involved in the successful Prime Minister's Challenge Fund bid which included workforce planning. The practice proactively

Summary of findings

sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.	

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding in caring and responsive for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example the percentage of patients aged 75 or over with a fragility fracture who were treated with an appropriate bone-sparing agent was 100% which was higher than the national average of 81.29%. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The three care homes the practice visited told us that staff offered a compassionate and responsive service that met patients' needs. They told us the GPs provided a responsive service above and beyond their expectations. As well as appointments and home visits to patients residing at three local care homes, they visited care home patients after the practice was closed, to provide comfort visits when required.

The practice provided increased flexibility of access to appointments and could demonstrate the impact of this by reduced use of the out-of-hours service and very positive patient survey results.

It funded a walking/exercise for health group, physiotherapy, chiropody, a meditation group for mindfulness sessions and a counsellor for its registered population as well as providing a dispensing service at both its locations. The practice provided almost a "one stop shop" for patients to access health and community services. For example, they facilitated Citizens Advice Bureau weekly sessions each Monday for the local registered community. The practice worked very closely with other health professionals and community and voluntary services and they were focused on using every opportunity for health promotion. These services were all funded and staffed by the practice. These practice brought these services closer to patients' homes, within a rural community, which benefited older patients and those with reduced mobility.

People with long term conditions

Good ●

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease

management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. It provided increased flexibility of access to appointments and could demonstrate the impact of this by reduced use of the out-of-hours service and very positive patient survey results. It funded a walking for health/exercise group, physiotherapy, chiropody, a mediation group for mindfulness sessions and a counsellor for its registered population as well as providing a dispensing service at both its locations.The practice offered all blood taking on-site along and electrocardiogram (ECG) testing, (this records the electrical activity of the heart to detect abnormal rhythms and the cause of chest pain). The practice provided diabetic foot screening along with aortic aneurysm screening (a swelling of a major artery called the aorta) to the local area at the practice branch location.

Families, children and young people

Outstanding ☆

The practice is outstanding in caring and responsive 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.

Staff demonstrated a good understanding and were proactive in safeguarding and protecting children from the risk of harm or abuse. The practice had a clear means of identifying in records those children (together with their parents and siblings) who were subject to a child protection plan and who were in looked after conditions. The practice had appropriate child protection policies in place to support staff and staff were trained to a level relevant to their role.

Immunisation rates were at 100% with the exception of the percentage uptake of one vaccine which was still higher than the CCG and national averages for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

We saw that the percentage uptake of cervical screening was 84.46% which was higher than the national average of 81.89%.

Summary of findings

The practice had reached out to the local community by supporting patients for minor illness who were not necessarily registered at the practice but attended a children's adventure group should the need arise.

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. It provided increased flexibility of access to appointments which included GP telephone appointments and could demonstrate the impact of this flexibility by reduced use of the out-of-hours service and very positive patient survey results. It funded a walking for health/exercise group, physiotherapy, chiropody, a mediation group for mindfulness sessions and a counsellor for its registered population as well as providing a dispensing service at both its locations.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding in caring and responsive for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had carried out annual health checks for people with a learning disability and all had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice worked with the local CCG in accepting patients who may be experiencing difficulties in registering with other practices for a variety of reasons whose circumstances may make them vulnerable. Historically, the practice have always been happy to take

difficult patients from surrounding practices. For example patients who had been removed from practices due to violence or aggressive behaviour. The practice engaged with the police and social services in meetings around vulnerable adults.

The practice had reached out to the local community by supporting people with learning disabilities who attended a local farm should the need arise for minor illness. If any underlying health issues were identified the patients (if they belonged to the practice) were offered an appointment at the practice and patients from other practices were advised to attend their own GP.

Together with the local church, the practice was involved in delivering food bank packages to people whose circumstances may make them vulnerable.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Seventy-six point nine per cent of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice provided a meditation group for mindfulness sessions and a counsellor for its registered population, a walking for health group as well as providing a depression questionnaire noted as validated for use in primary care, on its website. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice had written a document for residential care home patients relatives regarding what to expect with end-stage dementia and also provided information on the support available.

Summary of findings

What people who use the service say

We spoke with 14 patients during the inspection and received 80 completed Care Quality Commission (CQC) comments cards in total. All of the patients we spoke with said they were very happy with the service they received.

The National GP patient survey January 2015 results for this practice found that 99% of patients who responded said the last GP they saw or spoke to was good at giving them enough time and 98% said the last GP they saw or spoke to was good at listening to them. This was based on findings from the 122 surveys returned out of the 249 surveys sent out, giving a 49% completion rate. The survey found that 100% of respondents found it easy to get through to the practice by phone, which was excellent and higher than both the local Clinical Commissioning Group (CCG) average and the national average. The percentage of patients that would recommend their practice was 95% which was higher than the CCG average of 83% and national average of 78%. Ninety-eight per cent of patients in the survey described their overall experience of this practice as good which was higher than both the CCG and national average.

There was an active Patient Participation Group (PPG) at the practice which had been operational for over five years and had 15 members who held meetings with the GPs between four and five times per year. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice clearly demonstrated that they engaged regularly with the PPG and had worked with the PPG in the development of the practice and its future strategy and the practice mission statement was written by the PPG.

Patients could speak confidentiality at the reception desk and were aware they could ask to speak to the reception staff in another room if they wanted further privacy. Patients we spoke with told us they were aware of chaperones being available during examinations. They told us staff were helpful and treated them with dignity and respect. We were told that the GPs, nurses and reception staff explained processes and procedures and were available for follow up help and advice. They were given printed information when this was appropriate.

Areas for improvement

Action the service SHOULD take to improve

Complete an Infection and Prevention Control audit.

Ensure that the practice maintains appropriate recruitment records and introduce systems to verify staffs registration with their appropriate professional bodies.

Outstanding practice

The practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced use of accident and emergency facilities and the out-of-hours service, and positive patient survey results.

The practice had reached out to the local community by supporting people with learning disabilities who attended a local farm and a children's adventure group should the need arise, for minor illness. The practice also supported the local church initiatives, for example in delivering food bank packages.

The practice funded and facilitated a walking for health group at the local village hall.

The practice funded physiotherapy, chiropody, a meditation group for mindfulness sessions and a counsellor for its registered population.

The practice provided weekly comfort visits as well as appointments and home visits to patients residing at three local care homes.

Summary of findings

The practice worked with the local CCG in accepting patients who may be experiencing difficulties in registering with other practices for a variety of reasons whose circumstances may make them vulnerable.

Brown Clee Medical Centre

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

Background to Brown Clee Medical Centre

Brown Clee Medical Centre is located in Ditton Priors, Bridgnorth, Shropshire with a branch location in Stottesdon. It is part of the NHS Shropshire Clinical Commissioning Group. The total practice patient population is 3,300. The practice has a higher proportion of patients aged 65 years and above (33.6%) which is higher than the practice average across England (26.5%). The rural practice locations provide a service to a high percentage (39%) of patients who either work the land (26%) for example farmers, and those who provide services to the rural community (13%) figures as noted by the Office of National Statistics 2011.

The staff team currently comprises a male and female GP partnership. The practice also has a portfolio GP who provides clinic sessions weekly on a Friday, and the practice is also a host for an NHS England Support Team GP. NHS England Support Teams support the commissioning of high quality services and directly commission primary care and specialised services at a local level across England. The practice team includes two part time practice nurses, a practice manager/dispenser, a dietician, physiotherapist, accounts manager, cleaners, two dispensers, two receptionist/dispensers, two reception clerks and an administrator for document scanning. The chiropodist has very recently retired. In total there are 21 staff employed either full or part time hours.

At the Ditton Priors location the practice opening times are 8am to 6pm Monday to Friday. At the Stottesdon location, the opening times are 9am to 4pm Tuesday, Thursday and Friday and on Monday and Wednesday the opening times are 9am to 12.30pm. The GPs are contactable at the practice, for example for the residential care homes, from 7am to 7pm Monday to Friday. 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 switch to the out of hours service at 6pm each weekday evening and at weekends and bank holidays.

The practice provides a number of clinics, for example long-term condition management including asthma, diabetes and high blood pressure. It also offers child immunisations, minor surgery, photodermatology (Photodermatology is the use of photography to gain a diagnosis using a dermatoscope, the results are emailed to a consultant in Dermatology) and minor illness support for the learning disability individuals who attend a local farm and for a children's adventure group in Stottesdon. The practice provides comfort visits to patients living in the local nursing home and two residential care homes between 6.30 and 7.30pm when required. The practice was also involved in delivering food bank packages along with the local church. The practice facilitates a meditation 'Mindfulness' group to support patients' mental, physical and emotional wellbeing. The practice offers a walking/ exercise group from the local village hall, health checks and smoking cessation advice and support. The practice operates dispensaries from both the Ditton Priors and the Stottesdon locations.

Detailed findings

Brown Clee Medical Centre supports the training for medical students in years three and five from Keele University.

The practice works with the local CCG in accepting patients who may be experiencing difficulties in registering with practices for a variety of reasons. A counsellor attends the practice each Thursday funded via a local CCG initiative. The practice accesses case co-ordinator staff that provide case management and co-ordinated integrated care support which is a local CCG initiative.

The practice is a participant in the successful bid for the Prime Ministers Challenge Fund for the West Midlands Primary Care Workforce and Improved Patient Access Plan in Stafford, Shropshire and Telford and Wrekin. This pilot covers 36 GP Practices serving a patient population of 350,000 to provide the workforce and technology necessary to develop and deliver those services required to meet a significant proportion of Primary Care demand on the NHS locally.

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract for the practice to deliver general medical services to the local community or communities. They also provide some enhanced services, for example they are a dispensing practice, offer minor surgery and have Directed Enhanced Services, such as the childhood vaccination and immunisation scheme and extended hours access for their patients.

Why we carried out this inspection

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

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

How we carried out this inspection

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS Shropshire Clinical Commissioning Group, Healthwatch and NHS England Area Team. Clinical Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. We were not in receipt of information from the CCG prior to this inspection.

We carried out an announced inspection on 10 June 2015. During our inspection we spoke with a range of staff including GPs, practice nurse, practice manager, dispensary staff and reception staff. We observed how patients were communicated with and how the practice supported patients with health promotion literature. We reviewed 80 CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards had been made available to patients at both of the Brown Clee Medical Centre locations prior to the inspection.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances

Detailed findings

• People experiencing poor mental health (including people with dementia).

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an incorrectly labelled medicine. The action and learning points derived from this included improved checks on medicine labelling, some supervised dispensing sessions and protocol changes in that all medicines are checked by two dispensers or a dispenser and GP.

We reviewed safety records, incident reports and minutes of meetings where these were discussed since 2005. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda, the outcomes were shared on the practice electronic systems with staff and meetings were held to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, where the practice made a request made for home oxygen but it had not been fulfilled by the oxygen company. The action learning points were that the practice now contacts patients to check the oxygen has been delivered. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice electronic systems to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts, where relevant, were scanned into their electronic systems and saved in a specific folder for staff to access. Alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding with the exception of one staff member who was able to demonstrate they had this training planned. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with 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 to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

GPs were appropriately using 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 records demonstrated good liaison with partner agencies, such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The GPs informed us that they rarely, if ever, used hand written prescriptions. Following a home visit the GPs returned to the practice and prescribed electronically to ensure the patients medicine history, allergies and any medicine contra-indications could be fully explored. The medicines were dispensed according to the patients' choice of pharmacy.

We saw records of the actions taken in response to reviews of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. This included ensuring that all clinicians had access to a copy of the local prescribing guidelines and evidenced change in prescribing habits in line with the guidelines.

There was a system in place for the management of high risk medicines such as disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in

2015. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD from the prescriber.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

The practice had established a service for patients to pick up their dispensed prescriptions at both practice locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required. The practice had on rare occasions delivered vulnerable patients' dispensed medicines and were aware that appropriate policies procedures and safeguards were required.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example when dealing with spills of blood or bodily fluids. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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 and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We did not see evidence that the lead had carried out audits for each of the last three years. The practice nurse and GP told us that last audit was completed by the Shropshire Infection and Prevention of Infection Team which took place in 2011. The practice had demonstrated that any improvements identified for action were completed. The practice assured us that their Infection Control Lead would undertake an audit and implement any improvements accordingly.

Notices about hand hygiene techniques 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 staff toilet however required a hand towel dispenser.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. We found that the practices Information Technology (IT) systems such as the computers were not included in the testing. The practice manager and GP assured us that the separate company responsible for their IT would be contacted and advice taken in this regard.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it should follow when recruiting clinical and non-clinical staff. Records we looked at however were incomplete and did not contain all the evidence to suggest that the practice policy had been followed and that appropriate recruitment checks had been undertaken prior

to employment. For example, three of the five files reviewed did not contain proof of identification or references. The practice had informal systems in place to ensure staff maintained their registration with the appropriate professional body which relied on the staff member providing this information. The practice did not have a system in place to verify this information with the appropriate professional bodies. The practice manager assured us these checks would be implemented immediately. The appropriate checks through the Disclosure and Barring Service had been completed for all staff but in the five staff files reviewed we found that the outcome, dates and references numbers were only available to read in two. (These 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).

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 that enough staff were 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. Newly appointed staff had this expectation written in their contracts.

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 keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. We found that signs were not visible in the practice to ensure patients and visitors were aware that oxygen was in the building with details of the precautions they needed to observe. The GP and practice manager assured us that this would be addressed and the risk also added to their disaster recovery plan.

The practice had a risk assessment policy for example in its disaster recovery documentation and plan document which identified risks related to the practice. The practice had completed a risk assessment table where specific risks related to the practice were documented. We saw that each risk was reviewed and mitigating actions recorded to reduce and manage the risk. We saw that where risks were identified that action plans had been put in place to address these. Risks associated with the service and staffing changes (both planned and unplanned) were included in the risk assessment. For example these included fire risk assessments and safety of medical electrical equipment.

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, there were emergency processes in place for patients with long-term conditions; referrals made for patients whose health deteriorated suddenly and the practice monitored repeat prescribing for patients receiving medication for mental ill-health. Staff we spoke with told us that children were always provided with an on the day appointment if required.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

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

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in October 2014.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. The GPs told us that they had discussed that local access to a diabetic specialist nurse would further improve the services to their patients. Our review of meeting minutes confirmed that this happened.

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

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last 12 months. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, focusing on the reduction in the use of anti-inflammatory medicines for patients on a diuretic (commonly known as water pills), and included patients with specific a diagnosis for example, diabetes and high blood pressure. The practice findings following improvements made were a slow fall in the use of this medicine overall.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example an audit was completed to see how effective the practice attempts to reduce the use of a medicine which had become a

Good

Are services effective?

(for example, treatment is effective)

controlled drug was also completed. The practice evidenced that through this audit they had effectively reduced the use of this medicine by 30% and identified a target group for further interventions.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. For example 86% of patients with diabetes had received an annual review. The practice QOF results were lower than the national average in the percentage of patient who had a specific blood sugar result in the preceding 12 month period. The practice were aware of the results and had focused on implementing improvements. The practice told us that there were eight patients with a learning disability registered with the practice and all had an agreed care plan in place.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

We saw there was a system in place that identified patients at the end of their life and staff at the practice told us that they had six patients on the palliative care register. There were alerts within the clinical computer system making clinical staff aware of their additional needs. The practice held multidisciplinary meetings every six weeks with other professionals involved in their care.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as learning disabilities. Structured annual reviews were also undertaken for people with long term conditions.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. We found for example that the practice had achieved 100% uptake in their childhood immunisation programme with the exception of the uptake of one vaccine which although was 86.2% and higher than the average local CCG of 83.0%.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the management of long term conditions. The practice facilitated medical student training and hoped in the future to become a training practice for doctors who were in training to be qualified as GPs.

Practice nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on

Good

Are services effective?

(for example, treatment is effective)

administration of vaccines and cervical cytology. Those with extended roles such as seeing patients with long-term conditions such as asthma were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice had policies in place to ensure that should poor performance be identified that appropriate action would be taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of-hours reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The number of emergency hospital admissions for 19 ambulatory care sensitive conditions per 1,000 head of population between April 2013 and March 2014 was 12.1% which was lower than the national average of 13.6%.

The practice held multidisciplinary team meetings every six weeks to discuss patients with complex needs, for example, those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care professionals as appropriate.

The practice provided and received support from two GPs who both worked at the practice one day per week. This assisted the practice by providing additional GP appointment availability and maintained continuity for those patients. The GPs had opportunity to maintain their clinical experience whilst working for NHS England.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patients' preferences for treatment and decisions. We found for example that all patients living in a care home had their care plans reviewed in the last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick

Good

Are services effective?

(for example, treatment is effective)

competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. The practice had audited the complete assessments of all their minor operations over the last five years following a request from NHS England. The practice used these forms of requests as an opportunity to learn and evaluate and develop their practice. The findings illustrated the practices need to use the Community-Based Surgery Audit (CBSA) to reduce time spent following a manual process and would allow a more useful practice based audit.

The practice had not needed to use restraint, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice monitored patients aged 75 or over with a fragility fracture who were treated with an appropriate bone-sparing agent and had achieved 100% when compared to the national average of 81.29%. One GP was involved with Osteoarthritis health promotion and is an Osteoarthritis Champion for a group of four local practices as well as their own. (Osteoarthritis is a condition that causes the joints to become painful and stiff). Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice offered all blood taking on-site along with electrocardiogram (ECG) testing, (this records the electrical activity of the heart to detect abnormal rhythms and the cause of chest pain). The practice provided diabetic foot screening along with aortic aneurysm screening (a swelling of a major artery called the aorta) to the local area at the practice branch location.

The practice's performance for the cervical screening programme was 84.46%, which was above the national average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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 was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for patients aged over 6 months to under 65years in the clinical risk groups was 55.34% which was higher than the national average of 52.29%.

- Childhood immunisation rates for the vaccinations given to under twos ranged from 86.2% to 100% and five year olds from 96.3% to 100%. These were all above the local CCG averages.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses. For example:

• 98% said the GP was good at listening to them compared to the CCG average of 91.4% and national average of 87.2%.

• 98.8% said the GP gave them enough time compared to the CCG average of 90.2% and national average of 85.3%.

• 98.7% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.2% and national average of 92.2%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 80 completed cards and all, without exception were extremely positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 14 patients and three members of the Patient Participation Group (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). All said the care provided by the practice was first class and that their dignity and privacy was always 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Reception staff were aware of the difficulties. Systems were in place to maintain patient's confidentiality. These included taking patients to a private room to continue a private conversation and transferring confidential telephone calls to a private room if a person rang the practice for investigation results. The national GP survey published in January 2015 found that 97% of respondents found the receptionists at the practice helpful which was higher than both the local CCG average and national average.

Staff told us that 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.

Patients could access the practice without fear of stigma or prejudice. Staff received specific customer care training and told us the training included how to deal sympathetically with all groups of patients.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

• 97% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86.5% and national average of 82.0%.

• 95% said the last GP they saw was good at involving them in decisions about their care which was higher than both the local CCG and national average.

• 99% said they had confidence and trust in the last nurse they saw or spoke to which was higher than both the local CCG and national average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

The practice nurses and GPs ensured that all care home patients registered at the practice had up to date care plans. We saw evidence that these were in place and regularly reviewed. Patients living with dementia and their carers and/or advocates were involved in the development of their planned care, involvement in agreeing these and patients where appropriate were offered information about end of life care planning. The practice ensured they held at least six weekly multi-disciplinary meetings with other health and social care professionals for patients with complex needs, end of life care planning and for palliative care.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

• 95% said the last GP they spoke to was good at treating them with care and concern which was higher than both the local CCG and the national average.

• 93% said the last nurse they spoke to was good at treating them with care and concern which was higher than both the local CCG and the national average.

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

Notices in the lobby area of the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. 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.

The practice also communicated with the care coordinator who rang mental health and patients living with dementia were needed on a daily basis as well as the GP's. The practice found this had also resulted in low psychiatry referral rates. The introduction of care co-ordinators was a CCG initiative, based on providing as much support through community settings, such as is possible to enable patients to live independently for longer. The practice had written a document for the residential care home patients relatives regarding what to expect with end-stage dementia and also provided information on the support available.

The practice supported its local community examples included; funding a walking for health group, the lead GP provided a mindfulness meditation group; the practice registered and had awareness of the support needs of young and older carers.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The GP and nursing team fitted in urgent patient appointments during their day and took time with patients to deliver health promotion and advice. The GPs and nurses supported each other as necessary to ensure the best possible service was given to patients. It was evident from our interviews that the whole team was passionate about their work and where they worked.

The practice told us they engaged regularly with the NHS England Area Team and Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. Clinical Commissioning Groups (CCG) are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example the practice was engaged in the successful bid for the Prime Minister's Challenge Fund and was one of the 36 practices selected. The successful bid was to look at the workforce, to support the delivery of extended services and openings hours, technology, to enable them to integrally link practice systems seamlessly together, and pathway design to look at the planning and setting up of an acute visiting service to support GPs to be able to focus on practice based complex care management.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice involved the PPG in its five to 15 year business and development strategy. The PPG met with the practice, NHS England and the CCG and was fully informed of its involvement with the Prime Minister's Challenge fund. The PPG was also an active participant in the development of the practice mission statement. The PPG gave numerous examples of how the practice responded to patients' needs, these included; the practice opening times, gaining a same day appointment for non-urgent appointments on almost all occasions, the availability of a dispensary at both its locations, a local physiotherapist, dietician, counsellor and a chiropodist. The local care homes and GPs informed us the practice provided comfort calls of an evening between 6.30-7.30pm for patients who required support as well as the GP service they provided. The three care homes the practice visited told us that staff offered a compassionate and responsive service that met patients' needs. The GPs provided a responsive service above and beyond their expectations and visited patients after the practice was closed to provide comfort visits when required.

The practice facilitated Citizens Advice Bureau weekly sessions each Monday for the local community. The practice supported the local church in delivering food bank packages. The practice provided a counsellor, physiotherapist, dietician, chiropodist, and minor illness support to its registered patients. They also provided a minor illness service for people with learning disabilities who attended a local farm and a local children's adventure group.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, earlier opening times for patients who worked on the land or needed to commute, longer appointment times were available for patients with learning disabilities and the availability of a dispensary at both its locations to meet the needs of the rural community. They provided additional local services for its community such as minor illness support for people with learning disabilities attending a local riding school and to the local children's adventure group. The practice provided later opening for patients such as patients whose work meant they needed to commute and met the needs of their higher than the national average proportion of patients aged 65 years and above (33.6%). There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The practice recognised the needs of different groups in the planning of its services. The practice at both locations was situated on the ground floor of the building. 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 both practice locations. Facilities for patients with mobility difficulties included designated car parking spaces and adapted toilet facilities, baby change facilities were also available. A hearing loop for patients with a hearing impairment was available.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

Access to the service

At the Ditton Priors location the practice opening times were from 8am to 6pm Monday to Friday. The GPs at the surgery were contactable at the practice, for example for the residential care homes, from 7am to 7pm Monday to Friday. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes by a named GP and to those patients who needed one and provided comfort calls of an evening between 6.30-7.30pm for those who required support.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and rated the practice well in these areas. For example:

• 91% were satisfied with the practice's opening hours, which was higher than both the local CCG and national average.

• 98% described their experience of making an appointment as good which was higher than both the local CCG and national average.

• 88% said they usually waited 15 minutes or less after their appointment time which was higher than both the local CCG and the national average.

• 100% said they could get through easily to the surgery by phone which was higher than both the local CCG and the national average.

Patients we spoke with were extremely satisfied with the appointments system and said it was easy to use. The patient views in the 80 CQC comments cards we received aligned with these views. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Appointments were available outside of school hours for children and young people and could be arranged to suit the local bus timetables. An online booking system was available and easy to use, telephone consultations where appropriate and the practice offered support to enable patients to return to work.

The practice took account of patients whose circumstances may make them vulnerable by offering services to support them, for example, longer appointments for those that need them, flexible appointments such as avoiding booking appointments at busy times for patients who may

find this stressful. Another example included supportive telephone calls made by the nurse on a weekly basis to patients who the practice recognised may be at risk of being socially isolated.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. There was information on the practice website and a poster in the waiting room which informed patients how to complain.

We looked at four complaints the practice had received for the period January 2013 to May 2015. We saw they had been responded to and dealt with in a timely manner and found the practice demonstrated openness and transparency when dealing with complaints. We saw practice meeting minutes that demonstrated complaints were discussed and learning from them was shared with staff and that complaints were a regular agenda item. This supported staff to learn and contribute to any improvement action that might have been required. We saw that lessons learned from individual complaints had been acted on.

Information contained in the complaint summary showed that an investigation had been carried out, that response letters were sent to patients, any trends to the complaints considered and reviewed and the issues discussed with staff involved. The report contained brief details of the complaint, the action to be taken to prevent reoccurrence, which included a review of clinical practice and policies and procedures where required and the outcome. The report also detailed the learning shared with all staff. This supported staff to learn and contribute to any improvement action that might have been required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five to 15 year strategy and business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and included the views of its PPG members. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). The PPG and its reference group devised the practice mission statement with the practice which included their commitment to the whole community, to strive to provide quality healthcare in a safe, trustworthy, accessible way, while working ethically and with compassion.

We spoke with seven members of staff. We found that most of the staff knew and understood the vision and values for the development of the practice. Staff knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at seven of these policies and procedures and staff confirmed that they were asked to read any updated policies and on their training induction. The practice manager informed us that policies and procedures were reviewed annually unless otherwise stated. We found some policies were undated and there was no documented evidence such as a cover sheet to state that staff had read them. The practice manager assured us this would be addressed.

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

The GPs and the practice manager took up active leadership roles for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at their six weekly practice meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example following a clinical audit on a disease modifying medicine all patients who take these medicines are now highlighted on the practices electronic system. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example in respect to improvements to the premises. The practice monitored risks on a monthly basis to identify any areas that needed addressing. We found that the practice had not completed an infection and prevention control audit, some staff recruitment records were incomplete and they had not introduced systems to verify staff registration with their appropriate professional bodies.

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

The practice manager and GP partners were responsible for human resource policies and procedures. The practice had clear awareness of workforce succession planning and was one of the 36 practices involved in the successful Prime Ministers Challenge Fund bid which included workforce planning. We reviewed a number of policies, (for example disciplinary procedures and the induction policy) which

Are services well-led?

Good

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

were in place to support staff. The electronic staff handbook was available to all staff, which included sections on equality and harassment and bullying at work. Staff knew where to find these policies if required. The practice had a whistleblowing policy available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

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

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

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the PPG, surveys and complaints received. It had an active PPG of 15 members which included representatives from various population groups such as, retirees, commuters, homeworkers, professionals, young mothers. The PPG noted that they had more female than male members. The PPG had not carried out a patient survey for 12 months as they had found that they always received positive responses. Patients could raise issues via the PPG who met with the practice GPs at least four times per year, any issues were immediately actioned and addressed by the practice and they fed back on actions and outcomes at subsequent PPG meetings. We spoke with three members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

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

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice provided medical student training for students at Keele University. The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.