Ironbridge Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ironbridge Medical Practice on 9 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led, services. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients told us they could usually get an appointment when they needed one, although they may have to wait for a pre bookable appointment with the specific GP. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

The provider should:

Summary of findings

- Maintain a log of significant events.
- Consider introducing a signing in and out system for medicines taken out of the practice.
- Introduce a system to check the GPs registration with their professional body is up to date.
- Complete the outstanding staff appraisals and continue to review annually.
- Publicise the assistance bell located near to the main entrance so patients are aware they can request assistance when accessing the building.
- Include the acknowledgement letter in the complaint record or record the date the letter was sent.
- Review complaints to identify any common themes or trends.
- Share the practice vision and values with staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. There was a system in place for reporting, recording, monitoring and reviewing significant events, 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.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. There was evidence of appraisals, although these needed to be completed for all staff. Staff worked with multidisciplinary teams to meet the needs of patients. For example, patients receiving end of life care.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect. They described staff as being understanding and professional. Good systems in place to support carers and patients to cope emotionally with their health and condition. Information to help patients understand the services available was easy to understand.

We saw that staff were respectful and polite when dealing with patients, and maintained confidentiality. Views of external stakeholders such as other health care professionals were positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients told us it was easy to get an appointment but they have to wait for an appointment with a GP of choice. Patients could book appointments in advance with urgent appointments available the

Summary of findings

same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. There had been significant changes in the management structure and clinical staff at the practice. The current GP partnership was formed in September 2014, with the salaried GP joining the practice in October 2014. There was a clear leadership structure in place, although the GP partners recognised they were still developing as a staff team. They had identified the challenges and areas for development and these had been incorporated into the business plan. Staff we spoke with were positive about working at the practice. They told us they felt supported to deliver safe, effective and responsive care. There was a very clear leadership structure and staff felt supported by management. The practice had recently set up a Patient Participation Group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The practice was working closely with the practice to improve services for patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Every patient over the age of 75 years had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice worked with the Care Navigator, who contacted patients to offer sign posting to local services available to them. It was responsive to the needs of older people and offered home visits and longer appointments as required. The practice identified if patients were also carers, and information about carer support groups was available in the waiting room.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. We found that the nursing staff had the knowledge, skills and competency to respond to the needs of patients with a long term condition such as diabetes and asthma. Longer appointments and home visits were available when needed. All of these patients were offered a review to check that their health and medication needs were being met. However, the practice recognised that due to recent staffing changes, not all patients were up to date with their review. The practice worked closely with a health trainer from the Healthy Lifestyle Hub, a service commissioned by the local Clinical Commissioning Group (CCG). The health trainer worked with patients to make changes to their lifestyle to assist with the management of their long term condition. For those people with the most complex needs, the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, children and young people who had protection plans in place. Appointments were available outside of school hours and the premises were suitable for children and babies. Urgent appointments were available and children would be seen if they presented at the practice after school. There were effective screening and vaccination programmes in place to support patients and health promotion advice was provided. New mothers and babies were offered a six week check.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. A range of on-line services were available, including medication requests and booking appointments. The practice offered extended hours one morning and one evening a week. Urgent and pre-bookable telephone consultations were also available. The practice offered all patients aged 40 to 75 years old a health check with the nursing team. Family planning services were provided by the practice for women of working age. Diagnostic tests, that reflected the needs of this age group, were carried out at the practice. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. We found that the practice enabled all patients to access their GP services. The practice held a register of patients with a learning disability and had developed individual care plans for each patient. The practice carried out annual health checks and offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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 is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health were offered an annual physical health check. Dementia screening was offered to patients identified in the at risk groups. It carried out advance care planning for patients with dementia.

The practice had access to a range of services to support patients with mental health needs. The practice worked with the Care Navigator, who signposted older patients and carers for support when needed. The health trainer attached to the practice told us

Summary of findings

they were able to refer patients through the Healthy Lifestyle Hub on to the referral pathway for depression. The practice had good links with the community mental health teams, including their out of hours service.

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Summary of findings

What people who use the service say

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

We looked at the national patient survey published in January 2015. Data showed that 94% of patients rated their overall experience of the practice as good, which was higher than the Clinical Commissioning Group (CCG) average (84%) and the national average (85%). The results showed that 86% of patients would recommend the practice to someone new to the area, which was higher than the CCG average of 75% and national average of 78%.

Areas for improvement

Action the service SHOULD take to improve

Maintain a log of significant events.

Consider introducing a signing in and out system for medicines taken out of the practice.

Introduce a system to check the GPs registration with their professional body is up to date.

Complete the outstanding staff appraisals and continue to review annually.

Publicise the assistance bell located near to the main entrance so patients are aware they can request assistance when accessing the building.

Include the acknowledgement letter in the complaint record or record the date the letter was sent.

Review complaints to identify any common themes or trends.

Share the practice vision and values with staff.

Ironbridge Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Ironbridge Medical Practice

Ironbridge Medical Practice is located within Telford and Wrekin and provides primary health care to patients living in Coalbrookdale and the surrounding villages. The practice holds a General Medical Services (GMS) contract with NHS England.

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

A team of two GP partners, a salaried GP, an advanced nurse practitioner and a health care assistant provide care and treatment for approximately 4272 patients. There is also a practice manager, an administrative assistant to the practice manager, a secretary, a reception supervisor and four receptionists. All of the GPs are female.

The practice is open between 8am and 6pm Monday to Friday. Appointments are from 8.40am to 11.50am and 2pm to 5.30pm Monday every day. The practice offers extended hours on Monday mornings with appointments between 7am and 8am and Tuesday evenings with appointments up to 7.30pm. Patients can book appointments up to six weeks in advance. The practice does not routinely offer an out of hours service to their own patients but patients are directed to the out of service The Shropshire Doctors' Co-Operative Limited (Shropdoc), when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme 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

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?

Detailed findings

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a district nurse, health visitor and the regional manager for a local care home where the practice delivered care and treatment to patients living there. We spoke with a health trainer who visits the practice twice a week to see patients referred for healthy lifestyle advice and guidance, and two members of the patient participation group (PPG) during our inspection. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We did this to help us to understand the care and support provided to patients by the practice.

We carried out an announced inspection on 9 July 2015 at the practice. During our inspection we spoke with the two GP partners, a salaried GP and an advanced nurse practitioner. We also spoke with two receptionists, the practice manager and administration assistant and nine patients. We observed how patients were cared for. We reviewed 15 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw that a receptionist had raised a significant event when the outside light was not working and a patient fell. Checking that the light was working had been added to the checklist for reception staff to complete prior to locking up the practice for the night.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of six significant events that had occurred during the last year and we were able to review these. Monthly significant events meetings were held to review and share learning from them. We saw that the practice had learned from these and that the findings were shared with relevant staff. All staff knew how to raise a significant event and were encouraged to do so. A log of significant events was not kept.

Staff used significant event forms to record events and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We looked at several of these significant events and saw they had been investigated in a timely manner and actions had been taken to prevent them from happening again. For example, a significant event was raised when a patient had been registered twice at the practice. We saw that the protocol for new registrations had been updated to include searches for same name, date of birth and checking when summarising notes that the NHS number matches.

National patient safety alerts were disseminated by the practice manager to practice staff. They also told us alerts were discussed at the most appropriate meeting to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice held registers for children at risk, and children with protection plans were identified on the electronic patient record. There was a lead GP for safeguarding at the practice, who could demonstrate that they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. There was a system in place that highlighted patients with caring responsibilities. This enabled the practice to involve carers in the care and treatment decisions for the person they cared for.

The senior GP partner had met with the health visiting team to establish a working relationship following the recent changes at the practice and within the health visiting team. We spoke with a representative from the health visiting team. They told us the GPs were proactive about sharing any concerns about families and feedback from families was that the practice was good, especially around access to appointments for children.

There was a chaperone policy in place at the practice for staff to refer to for support. Signs informing patients of their right to have a chaperone present during an intimate examination were clearly displayed throughout the practice. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional

during a medical examination or procedure). The nursing team usually acted as chaperones, although reception staff had also received training and the necessary checks had been completed.

Medicines management

Medicines at the practice were stored securely. Appropriate checks and procedures were in place to make sure refrigerated medicines were stored at the correct temperature. Arrangements were in place to ensure medicines were in date. We saw that patients' repeat prescriptions were reviewed regularly to ensure they were still appropriate and necessary. A 'grab bag' of medicines was available for GPs to take on home visits. A system to sign to this in and out of the building was not in place.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. We saw from the data we reviewed that the pattern of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were similar to national prescribing.

The advanced nurse practitioner (ANP) administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the ANP had received appropriate training to administer vaccines.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice was supported by the Clinical Commissioning Group (CCG) prescribing advisor. The prescribing advisor visited the practice to discuss the CCG prescribing incentives. They also advised the practice of any changes in guidance and carried out searches to identity patients on medicines where the guidance had changed. The prescribing advisor could suggest changes to patient medicines in response to updates if agreed by the GPs.

The practice used repeat dispensing to allow regularly used medicines to be issued by pharmacies at the correct time. This prevented over use of medicines and was more convenient for patients as it removed the need to request a repeat prescription each month.

Cleanliness and infection control

We observed the premises to be visible 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. There were hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

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. This policy had been reviewed and updated in June 2015. The recently appointed advanced nurse practitioner was the lead for infection control within the practice. They had started to carry out infection control audits, and had addressed areas that required attention, for example clinical waste bins with lids that were not foot operated or broken were replaced. Other staff were currently working through an e-learning training programme on infection control. An infection control audit had been carried out in October 2013 by the local Clinical Commissioning Group (CCG). The practice achieved an overall score of 89%% and produced an action plan to address the issues identified.

Reasonable steps to protect staff and patients from the risks of health care associated infections had been taken. Staff were assessed by the occupational health department and received immunisations relevant to their role. Spillage kits were available to manage any spillage of bodily fluids. A legionella risk assessment had been completed in December 2012 to protect patients and staff from harm. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that there were procedures in place to prevent the growth of legionella.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment maintenance logs that demonstrated that all electrical equipment had been

Good

Are services safe?

tested and maintained regularly. For example, all portable electrical equipment had been tested in April 2015 and medical devices were calibrated in May 2015 to ensure they were safe to use.

Staffing and recruitment

There were sufficient numbers of staff with appropriate skills to keep people safe. Staff rota systems were in place and holidays and sickness were covered internally. The practice had recognised shortfalls in particular areas of staffing. For example, they were advertising for an additional part time practice nurse, and had employed additional administrative support for the Practice Manager, so they could concentrate on a more strategic managerial role. The practice also employed a male locum GP once a month to offer male patients the opportunity to see a male GP.

Records showed that appropriate checks were undertaken prior to employing staff, such as identification checks and Disclosure and Barring Service checks. However, gaps in employment were not always explored and recorded.

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 environment, medicines management, 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.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

There were emergency procedures and equipment in place to keep people safe. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff had received cardio pulmonary resuscitation training, and a defibrillator was available, which staff were trained to use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included smell of gas and faulty fire alarm system. The business continuity plan included important contact numbers for use in the event of the loss of one of these services.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff routinely referred to guidelines from the National Institute for Health and Care Excellence (NICE) when assessing patients' needs and treatments. There was a system in place to inform staff of any changes in the NICE guidelines they used. The advanced nurse practitioner told us the nursing protocols were based on NICE guidelines.

The practice currently only employed one advanced nurse practitioner, who managed specialist clinical areas such as diabetes, heart disease and asthma with support from the GPs. Care was planned to meet identified needs and was reviewed through a system of regular clinical meetings. The practice acknowledged that due to the recent changes in nursing staff the recall system had not been as robust as it could have been and needed to be reviewed. Clinical staff told us they were open about asking for and providing colleagues with advice and support.

The GPs we spoke with used national standards for the referral of patients to other services. For example, two weeks for patients with suspected cancer to be referred and seen. The senior GP partner showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for prescribing medicines was in line with or below the levels agreed with the CCG.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The 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. We saw there was a system in place to review QOF data and recall patients when needed. The practice achieved 89.1% of QOF points which was below the local Clinical Commissioning Group (93.9%) and national average (94.2%). This practice was an outlier in three QOF (or other national) clinical target areas; dementia prevalence rates, diabetes and mental health. The practice had reviewed the data available and put action plans in place to bring about improvements in these areas.

The practice showed us four clinical audits that been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. For example, one of the GPs had reviewed the treatment of uncomplicated urinary tract infections to assess whether the GPs were prescribing antibiotics appropriately and correctly. The first audit cycle showed that patients were receiving the correct antibiotic with the correct frequency of doses, but only 80% of patients received antibiotics for the correct number of days. The audit highlighted that locum GPs were not always following the local Clinical Commissioning Group (CCG) guidelines. As a consequence, protocol was delivered and made available in each consulting room. Following the introduction of the protocol, a follow up audit was completed, which found that 89% of patients received the correct antibiotic for the correct number of days, an improvement of 9%. Other examples of audits included contraceptive coil audit and minor surgery.

There was a protocol for repeat prescribing that was in line with national guidance. In line with this, staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. As the practice was a QOF outlier for diabetes, the advance nurse practitioner had prioritised seeing patients who were overdue their review or their diabetes was less well managed.

The practice worked in line with the gold standard framework (GSF) for end of life care. GSF sets out quality standards to ensure that patients receive the right care, in the right place at the right time. It had a palliative care register and had regular meetings with the hospice outreach nurse to discuss the care and support needs of patients and their families. For example, the practice described how they had worked with the hospice outreach nurse and the community matron to support a patient and their carer (who also had chronic health needs) to remain in their own home. A completed CQC comment card referred to end of life care and the support the patient and family were receiving, including telephone contact as and when required.

The practice was a QOF outlier for patients with mental health needs. The practice had investigated why their

Good

Are services effective?

(for example, treatment is effective)

figures were low, and established it was partly due to a coding issue on the notes, and also due to the recall system. Patients were being seen by the community mental health team but not attending the practice for reviews. The practice introduced a more robust recall system, whereby they sent letters to the patients and contacted them by telephone to make appointments. They also flagged them on the electronic notes system so if they contacted the practice they were always offered a same day appointment. They described how they had worked with the community mental health team with a patient who presented with a medical problem. The patient was offered an appointment at the end of surgery so the GP had time to carry out a full physical health assessment as well as deal with the presenting medical condition.

Effective staffing

Staff had received training appropriate to their roles, and had protected learning time for ongoing training. The GPs had additional qualifications in sexual and reproductive medicine and women's health. The GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England. There was a system in place to check the advance nurse practitioner's registration with their professional body remained in date, although a similar system was not in place for the GPs.

Not all staff had received an appraisal within a twelve month period. The appraisal process had been reviewed and there were plans in place for those staff who had not had an appraisal to be appraised over the next few months.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. We spoke with a district nurse, health visitor and the regional manager of a local care home prior to our inspection. They told us the practice worked with them to meet the needs of patients and that there were effective communication pathways in place to support the sharing of information. Although regular meetings did not take place with the district nurses and health visitors, they told us the GPs were approachable and made time to see them if they called at the practice. They also told us the GPs were proactive about sharing relevant information with them.

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The duty GP dealt with the daily post and results and was responsible for the action required. All staff we spoke with understood their roles and responsibilities.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice offered a Choose and Book option for patient referrals to specialists. The Choose and Book appointments service aims to offer patients a choice of appointment at a time and place to suit them.

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, and commented positively about the system's safety and ease of use. 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

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care

Good

Are services effective?

(for example, treatment is effective)

plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision.

There was a practice policy for documenting consent for specific interventions. We saw that there was a form to obtain informed written consent for minor surgery.

Health promotion and prevention

The practice worked with a health trainer from the Healthy Lifestyle Hub, a service commissioned by the local Clinical Commissioning Group (CCG). The health trainer visited the practice twice a week to see patients referred by the GP or advance nurse practitioner, who have long term conditions, such as pre- diabetes and diabetes, heart disease, high blood pressure or high cholesterol. The health trainers worked with patients to make changes to their lifestyle to assist with the management of their long term condition. The health trainer told us patients were monitored for improved outcomes, for example weight loss, prevention of development of diabetes and lowered cholesterol levels. All consultations were recorded in the electronic patient notes. The health trainer told us they were able to refer patients through the Healthy Lifestyle Hub for onward referral to a range of health improvement services, for example smoking cessation groups, and the expert patient programme for patients living with long term/chronic conditions, including those living with depression.

The practice website contained health advice and information on long term conditions, with links to support organisations. Leaflets on health promotion and support groups were available in the waiting room.

The practice offered new patient health checks, and NHS checks for patients aged 40-75. All patients were allocated a named GP although they were able to see the GP of their choice when they visited the practice. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data collected by NHS England for 2013 -2104 showed that performance for all childhood immunisations was in line with or above the average for the local CCG. There was a clear policy in place to follow up non-attendees. The practice's performance for cervical smear uptake was in line with the national target of 80%.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had a register of 48 patients with a learning disability and these patients had received an annual health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were high risk of admission to hospital or those receiving end of life care. These groups were offered further support in line with their needs.

The practice worked closely with a care navigator from Age Concern. This post was funded by the local CCG. The care navigator worked with older people, including those living with dementia or mental health needs, and signposted people to local services available to them.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 111 replies to the national patient survey carried out during January-March 2014 and July-September 2014 and 50 NHS Friends and Family Test completed between January and June 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 showed that 94% of patients rated their overall experience of the practice as good, which was higher than the Clinical Commissioning Group average (84%) and the national average (85%). The survey showed that 96% of patients felt that the doctor was good at listening to them and gave them enough time. The survey also showed that 96% of patients felt that the nurse was good at listening to them and gave them enough time. All of these results were above the local CCG and national averages.

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

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

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt fully informed and involved in the decisions about their care. They told us they felt listened to and supported by staff, and the GPs were good at explaining things to them. Patients' comments on the comment cards we received were also positive and supported these views.

Information from the national patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas. For example, data from the survey showed 89% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. These were above the local CCG averages (79% and 83%) and national average (83% and 86%). The results were similar for the nurses, with 88% of practice respondents said the nurse involved them in care decisions and 93% felt the nurse was good at explaining treatment and results. These were above the local CCG averages (91% and 86%) and national averages (90% and 85%).

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice. For example, 91% of patients surveyed said that the last GP they saw or spoke with was good at treating them with care and concern compared to the local CCG average of 83% and national average of 85%. The results were similar for the nurses with a score of 94% compared to the local CCG (91%) and national average (90%). The patients we spoke with during the inspection and the comment cards we received were also consistent with this survey information.

Notices in the patient waiting room, information in the practice booklet and on the patient website informed patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Information about the local carers support group was on display in the waiting room.

Good

Are services caring?

Two patients spoken with during our inspection told us the practice was very supportive of carers and they couldn't fault the care and support both they and their relative had received.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice offered a range of enhanced services, for example invasive minor surgery, coil and implant fitting and childhood immunisations and travel vaccinations. The practice also provided a range of clinics for the management of long term conditions, such as asthma, chronic obstructive airways disease (COPD), heart disease and diabetes.

The practice recognised that approximately 50% of their patients were aged between 18 and 64 years old, and had planned services accordingly. For example, extended hours one morning and one evening a week, pre bookable telephone consultations, and on line services for appointments and prescriptions.

The practice had recently set up a Patient Participation Group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. Although the PPG had only been meeting since January 2015, the practice had listened to suggestions they had made. For example, staff stated who they were when they answered the telephone, pens on the reception desk to complete the NHS Friends and Family Test or write down appointments and updating the information on notice boards, and providing the PPG with their own notice board. The practice and PPG were currently working together to look at the 'did not attend' (DNA) rates for GPs.

Tackling inequity and promoting equality

The practice had provided equality and diversity training through e-learning for all the staff. The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground and first floors of the building with services for patients provided on the ground floor. The waiting rooms were large enough to accommodate patients with wheelchairs and prams. The access to the main entrance had automatic doors, although the doors through to the waiting room and consulting rooms were not. Patients requiring assistance could alert staff by ringing a bell located near to the main entrance, although this was not well published. Facilities for patients with mobility difficulties included a disabled parking space; step free access to the front door of the practice; a disabled toilets and a hearing loop for patients with a hearing impairment.

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

The practice provided care and support to patients who lived in a local care home for people with learning disabilities. We spoke with the regional manager. They told us they worked in partnership with the practice to meet the needs of the patients and spoke highly of the GPs. They told us the practice was very responsive and the GPs always visited on request, although the majority of patients usually visited the practice. Patients over 75 years of age and those patients with an end of life care pathway in place had a named GP to ensure continuity of care. There were no homeless patients registered with the practice although the practice occasionally provided care for tourists visiting the local area. These people were supported to access the service without difficulty.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the practice's website. The contact telephone arrangements for the out of hours service was in the practice leaflet and on the website. An answerphone message directed patients to the out of hours service if they telephoned the practice when closed.

The practice was open between 8am and 6pm Monday to Friday. Appointments were from 8.40am to 11.50am and 2pm to 5.30pm every day. The practice offered extended hours on Monday mornings with appointments from 7am until 8am and Tuesday evenings with appointments up to 7.30pm. Advance appointments with the GPs and advance nurse practitioner were pre-bookable up to six weeks in advance. Same day appointments and telephone consultations were also available and any patient who requested to be seen urgently would be either contacted by telephone or seen the same day. The practice offered 10 minute appointments to patients but also blocked two appointments during a session, to enable the GPs to catch up and get back on time of appointments had

Good

Are services responsive to people's needs?

(for example, to feedback?)

run over. The practice did not routinely offer an out of hours service to their own patients but patients were directed to the out of service Shropdoc, when the practice as closed.

Patients told us they could usually get an appointment when they needed one, although they may have to wait for a pre bookable appointment with the specific GP. These comments were similar to those made on the comment cards. Urgent appointments were available for the day of the inspection and routine appointments within five days of the inspection. The data from the national patient survey indicated that 82% of respondents were able to get an appointment or speak to someone the last time they tried, which was slightly lower than the local CCG (84%) and national average (85%). We saw 80% of respondents said their experience of making an appointment was good, which was above the local CCG (71%) and national average (74%). Patients did comment that occasionally they were not seen at their appointment time. This was reflected in the data from the patient survey, where 62% of respondents said they usually wait 15 minutes or less after their appointment time to be seen. This was slightly below both the local CCG (66%) and national average (65%).

Longer appointments were available for older people and patients with complex needs. Patient notes were flagged to ensure all staff were aware of this when booking appointments. Home visits were offered to patients who were unable to or too ill to visit the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated person who handled all complaints in the practice. Information on how to complain was in the practice leaflet, on the website, posters were on display and complaint forms available in reception.

We looked at a summary of complaints made during the last 12 months and reviewed a number of complaints in detail. Although discussions with the practice manager supported that complaints were responded to within the practice's policy timeframes, the records did not ways support this as acknowledgment / holding letters were not of file, or the date sent recorded. All complaints were raised as significant events, and investigated using the significant event process. The practice discussed complaints with staff at the appropriate staff meeting, and was able to demonstrate changes made in response to feedback, such as changes in the way the repeat prescriptions were set up. However, they had not reviewed complaints over time to identify any common themes or trends.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients, and that patients were placed at the centre of their care. A business plan had been developed following the recent changes in the management structure. The vision and values for the practice were included in the business plan. The plan was continually being reviewed and updated as the management team developed. The management team were aware that they needed to share the vision and values with staff. However, discussions with staff demonstrated that the practice operated in a way that placed patients at the centre of their care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available in paper form and electronic. The management team were aware that the policies and procedures needed to be reviewed and updated, and there was a plan in place to achieve this. A number of policies had already been updated, for example the infection control policy and safeguarding policy. There were systems in place to monitor quality and identify risk. Data from the Quality and Outcomes Framework (QOF) showed the practice was performing slightly below national standards in certain areas. The practice had taken action to improve in these areas.

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 one of the partners 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 told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

Leadership, openness and transparency

There had been significant changes in the management structure and clinical staff at the practice. The current GP partnership was formed in September 2014, with the salaried GP joining the practice in October 2014. The advanced nurse practitioner had been in post for five weeks, although had previously worked at the practice. The practice manager had been in post for just over 12 months, and there had been changes to the reception and administration team.

Staff described the culture at the practice as open and transparent.

Regular meetings were held at the practice and staff felt confident to raise any issues or concerns at these meetings. There was a practice whistle blowing policy available to all staff to access. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

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 patient participation group (PPG), NHS Friends and Family Test and complaints received. The practice had recently set up a Patient Participation Group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. Members of the PPG recognised that the group did not include representative from all of the various population groups, and they were actively trying to recruit members from the younger age groups. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. Information about the PPG and minutes of the meetings were on display in the waiting room.

Staff told us they felt confident giving feedback, and this was recorded through staff meetings. 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

The management team were committed to developing the practice through learning and improvement. All staff would

Are services well-led?

Good

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

receive an appraisal to identify their learning needs. The advanced nurse practitioner, although new in post, told us that the practice would support them to maintain their clinical professional development through training. The practice was very supportive of training and staff attended protected learning events three times a year organised by the local Clinical Commissioning Group. The practice also arranged its own internal training events and all staff received on line training.

The practice was able to evidence through discussion with the GPs, staff and practice manager and via documentation that there was a clear understanding among staff about safety and learning from incidents. We found that concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated, actioned and discussed at meetings.

The practice was actively engaged with the local Clinical Commissioning Group (CCG) and therefore involved in shaping local services. The senior GP partner and practice manager attended the locality meetings and communicated the information to other members of the team. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted. The other GP partner was involved with the local out of hours service The Shropshire Doctors' Co-Operative Limited (Shropdoc).