Church Stretton Medical Centre

Quality Report

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Date of inspection visit: 11 November 2014
Date of publication: 19/02/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 11 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided outstanding care to older people. They provided good care to people with long term conditions, families, children and young people, working age people, people in vulnerable groups and people experiencing poor mental health.

Our key findings were:

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

We saw areas of outstanding practice including:

- The practice was found to be extremely proactive in developing strong local and international community links for the benefit of its own and other patient population groups. For example the practice had

Summary of findings

secured funding from the Clinical Commissioning Group (CCG) to enable extra support for patients in their own home through the 'Care 4 me at home' project.

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

- Evaluate the effectiveness of the system used to store policies and procedures to ensure staff have easy access to relevant information to support their individual roles.
- Consider ways to strengthen the risk management processes within the practice to ensure that all risks are assessed and rated, with mitigating actions recorded to reduce and manage risks, including fire safety, recruitment and electrical and water testing

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 report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Systems were in place to assess risks to patients and staff, however these needed to be reviewed to ensure all potential risks were reduced and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. The National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced. The practice was extremely proactive in working with other professionals and the local community.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision and 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 regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the population group of older people. The practice had a large percentage of its practice population in the older age group. This was more than double the national average. An example of outstanding practice was how the practice had proactively sought to secure funding from the Clinical Commissioning Group to enable extra support for patients in their own home through the 'Care 4 me at home' project.

Other examples of outstanding practice were the range and number of multidisciplinary partnerships that the practice engaged with, and referred patients to their services. This included a local project which enabled and promoted vulnerable people to retain their independence which had won a national award for its work within the community. The practice also referred patients to a consultant psychogeriatric and memory assessment service.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in placeand referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. Home visits for elderly patients with long term conditions were carried out. For those people with the most complex needs a named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following up children and young people living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. The practice provided a female health clinic and used in house expertise to reduce unnecessary referrals to other services. The practice provided chlamydia screening packs to enable young people to carry out self referrals if required. We were provided with

Summary of findings

good examples of joint working with other professionals such as midwives and health visitors. Emergency processes were in place and necessary referrals were made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age population, those recently retired and students. The needs of this population group had been identified and the practice had adjusted the services it offered to ensure services were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs at the practice attended vulnerable families meetings with other health professionals such as health visitors to ensure the ongoing needs of these patients were met. The practice had signposted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had direct access and made referrals to a consultant psychogeriatric and memory assessment service. It also referred patients to a registered mental health liaison nurse in the local community mental health team who held regular weekly clinics at

Summary of findings

the practice. The practice held a register of patients with severe mental illness and carried out health checks with them at least annually. Some staff had received training on the Mental Capacity Act 2005 and others had training on mental health awareness.

Summary of findings

What people who use the service say

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

We spoke with the chair of the Patient Participation Group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. They told us that they felt well supported by the practice and the staff who attended the PPG meetings. We reviewed the 27 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. All of the comment cards contained highly positive feedback about the service provided by the practice. Patients told us that all staff, including reception staff were respectful and treated them with dignity. There were two comments about being seen by a GP later than the allocated time, however these two patients felt the care was excellent when they were seen.

We looked at the national GP Patient Survey information published in December 2013 which found that 90% of patients rated the practice as good or very good. This was above the Clinical Commissioning Group's (CCG) regional average and based on 130 responses. The chair of the PPG told us that the PPG carried out patient surveys each year and a comments box was also available in the waiting area for patients. The chair confirmed to us that any suggestions for improvement made by them or other patients were listened to and actioned by the practice.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Evaluate the effectiveness of the system used to store policies and procedures to ensure staff have easy access to relevant information to support their individual roles.
- Consider ways to strength the risk management processes within the practice to ensure that all risks are assessed and rated with mitigating actions recorded to reduce and manage risks, including fire safety, recruitment and electrical and water testing

Outstanding practice

The practice was found to be extremely proactive in developing strong local and international community links for the benefit of its own and other patient population groups. For example the practice had secured funding from the Clinical Commissioning Group (CCG) to enable extra support for patients in their own home through the 'Care 4 me at home' project.

Church Stretton 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 specialist advisor, a practice manager specialist advisor and an expert by experience who had personal experience of using primary medical services.

Background to Church Stretton Medical Centre

Church Stretton Medical Practice is a general practice located in Church Stretton in Shropshire. It is also a teaching practice for fully qualified doctors to gain experience and higher qualifications in general practice and family medicine. In addition, it provides training and supervision for medical students.

The practice has six GPs, three male and three female, all part time. There is a practice manager, an assistant practice manager, a lead nurse, three practice nurses and two healthcare assistants. There is a medical secretarial team, a reception team and administrative staff. There are in excess of 7,300 patients registered with the practice (as at 31 March 2014). The practice is open from 8.30am to 6.00pm Monday to Friday and closed for one hour from 1.00pm to 2.00 pm on a Wednesday each week.

The practice treats patients of all ages and provides a range of medical services. Church Stretton Medical Practice has a large percentage of its practice population in the older age group which is more than double the national average.

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

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

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

Detailed findings

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

Before the inspection we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 November 2014. During We spoke with ten patients who used the service about their experiences of the care they received. We talked with carers and/or family members and reviewed relevant documents. We reviewed 27 patient comment cards sharing their views and experiences of the practice.

Good

Are services safe?

Our findings

Safe Track Record

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

they were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We saw a record which showed that one of the receptionists took prompt action and escalated their concerns to the practice nurse in relation to a very poorly child. We saw that the practice nurse took appropriate steps to deal with the emergency to the benefit of the patient.

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

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. The GPs at the practice held a daily meeting and they confirmed that urgent significant events were discussed daily if needed. Significant events were also discussed at the monthly practice meetings and time was dedicated to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms/cards were available for staff in the reception area. Once completed these were dealt with immediately by the practice manager and monitored. We saw evidence that each incident was discussed at the practice meetings and that records were completed in a comprehensive and timely manner. Evidence of action taken as a result of reporting incidents was shown to us. For example we saw that there had been an incident involving a patient's blood test result. Staff identified the error and took action to report and address the issue.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details of other relevant agencies were not easily accessible. The system used by the practice to store policies and procedures appeared to be difficult for staff to use to find relevant information.

Records we looked at showed that appropriate recruitment criminal record checks had been undertaken for all clinical staff. We did not see appropriate checks had been carried out for all reception and administrative staff and no risk assessments had been completed to determine if a check was needed.

The practice had a GP who was appointed as the lead in safeguarding vulnerable adults and children. We saw that all staff had undertaken training in safeguarding vulnerable adults. All the GPs and two practice nurses had been trained to level 3 in safeguarding children. All staff we spoke with were aware of who to speak to in the practice if they had a safeguarding concern. We saw a summary sheet was available for staff which explained the steps they should take if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example if a patient was also a carer or had a learning disability. The system enabled the identification and follow up of children, young people and

families who were living in disadvantaged circumstances. This included children in need and children on a protection plan and the review of repeat medications for patients with multiple health needs.

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

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

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

Medicines Management

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

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

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

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

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, it described how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Staff told us that those who had responsibility for managing the repeat prescriptions service received training from the GPs and the community pharmacist as and when required.

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

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.

Cleanliness & Infection Control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that training had been provided for staff by the lead for infection control. We saw that a recent infection prevention and control audit had been completed by the lead for infection control at the

Good

Are services safe?

Clinical Commissioning Group (CCG). We saw that there were some areas for improvement identified which included the need for cleaning schedules to be in place. The practice manager confirmed that action had already begun to address these areas.

An infection control policy was available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice had carried out informal checks of the water system and were in the process of accessing an external company to carry out a more in-depth check of the system to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment logs and other records that confirmed this. We did not see any evidence that portable electrical equipment was routinely tested nor stickers indicating the last testing date. There was a schedule seen of visual checks of electrical equipment carried out by staff. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer which took place annually.

Staffing & Recruitment

Records we looked at for clinical staff contained evidence that appropriate recruitment checks had been undertaken prior to employment for those individuals. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

However, we did not see DBS checks had been carried out for all reception and administrative staff and no risk assessments had been completed to determine if a check was required. Following the inspection the practice manager confirmed that risk assessments had been completed for these staff who would not undertake any chaperoning duties with patients.

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 they were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave when required.

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

Monitoring Safety & Responding to Risk

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

Identified risks were recorded and discussed with staff. This information was seen to be kept in a number of places and it was not possible to determine if all risks were assessed and rated with mitigating actions recorded to reduce and manage the risk. Staff confirmed that risks were discussed at practice meetings and within team meetings. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

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

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

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

We saw that a fire risk assessment had been completed, however this needed to be more robust and in line with government best practice guidelines to ensure that all the fire precautions in the practice remain current and adequate. Staff confirmed that weekly fire alarm checks were carried out and records seen confirmed this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw evidence of new guidelines being shared amongst the team. We saw records which highlighted how the guidance may impact on the practice's performance and any implications for patient care were discussed. Records showed that required actions were agreed and followed through. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

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

The GPs told us they each had a lead role in specialist areas such as diabetes, asthma, family planning and mental health. The practice nurses supported this work which allowed the practice to focus on specific conditions. We saw that a GP and a practice nurse were trained specifically in the treatment of diabetes. Another GP had completed training on the Mental Capacity Act 2005 and three GPs had received mental health training. One GP with a specific interest in patients with a learning disability had completed relevant training in this area. This helped to improve the service offered for those patients when invited for their annual health checks.

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

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

Management, monitoring and improving outcomes for people

The practice told us about four clinical audits that had been undertaken in the last six months. We saw the practice was able to demonstrate the changes since an initial audit on the infection rate for those patients who received minor surgical procedures. Other examples of clinical audits included a ring pessary audit which had led to the installation of a recall system at the practice for these patients. The second cycle of this audit had yet to be undertaken and reflected on.

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

We saw that the practice performed minor surgery, long acting contraceptive implant insertion and intra uterine devices and systems. We saw that an annual audit of all patients receiving the service was returned to the local CCG and accrediting body in line with national requirements. We were told that the practice nurse who had responsibility for chronic disease management carried out home visits to complete annual reviews for all patients who had a long term condition and were house bound. All of these patients were elderly.

Good

Are services effective?

(for example, treatment is effective)

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts and recommendations when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of 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. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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

Effective staffing

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

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

All staff undertook annual appraisals which identified training and development needs and performance objectives and agreed dates for completion. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example basic life support.

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

Working with colleagues and other services

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

We were provided with a number of examples where the practice worked well with other services. For example, one of the GPs told us about the community centre, Mayfair, which was located next door to the practice. This community centre was the focus for the 'Care 4 me at home' project for which the practice had secured funding from the CCG to enable extra support for patients in their own home. The GP met regularly with the stakeholders in this project to update, feedback and fine tune details to ensure the project was meeting the needs of the patients involved.

Another example was the partnership that the practice had with a community in Ethiopia. A charity was set up to support healthcare in a community in the Highlands, North of Addis Ababa. The practice had developed community to community links, not only with the medical centre but also with local schools and a nursery, providing much needed equipment and funding the supply of clean water. We saw photographs and information displayed in the practice about this project.

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

Good

Are services effective?

(for example, treatment is effective)

the usefulness of the forum as a means of sharing important information. The practice also had direct access and made referrals to a consultant psychogeriatric and memory assessment service.

Information Sharing

The practice used an electronic system to make referrals and to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice made referrals through the Referral Assessment Service in discussion with the patient. (The Referral Assessment Service enables patients to choose the services and appointments appropriate to their condition).

The practice had signed up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating unfamiliar patients in an emergency situation or out of hours with faster access to key clinical information.

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

Consent to care and treatment

We saw that the practice had a consent policy and mechanisms to seek and record consent decisions were in place. For example we saw that the need for minor surgery carried out at the practice and the risks involved had been clearly documented and explained to patients.

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

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

Health Promotion & Prevention

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

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

There was a policy to send reminder letters to patients who did not attend for follow up appointments, including those for cervical screening for example. We saw that the practice audited patients who did not attend for annual checks and had a number of mechanisms to follow up patients who had missed their appointments.

The practice offered a full range of immunisations for children, travel vaccines and 'flu' vaccinations in line with current national guidance. Last year's performance for most immunisations was above average for the practice and there was a clear policy for a named practice nurse to follow up patients who did not attend.

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

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

Good

Are services effective?

(for example, treatment is effective)

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

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 506 patients undertaken by the practice's Patient Participation Group (PPG). The evidence from 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 rating the practice as good or very good. The practice was also well above average the Clinical Commissioning Group (CCG) regional average for its satisfaction scores on consultations with doctors and nurses. The survey showed that 93% of practice respondents saying the GP was good at listening to them and 90% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 27 completed cards and all of the feedback was overwhelmingly 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 ten patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

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

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed the actions taken had been robust. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients were generally satisfied about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both of these results were slightly below the CCG's regional average, however 90% of respondents felt their overall experience of the practice was good.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them. They told us that they felt involved in decision making about the care and treatment they received. They also told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was 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 also saw a poster in the waiting area which provided a pictorial representation of ailments for patients who were not able to communicate verbally.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a multidisciplinary team (MDT) approach with district nurses and palliative care nurses. We saw that the Gold Standard Framework (GSF) palliative care meetings were held and

Good

Are services caring?

recorded. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care, where they chose.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

We saw that there were notices in the patient waiting room, on the TV screen and patient website which signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown written information which was available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used a risk tool which helped GPs detect and prevent unwanted outcomes for patients. This helped to profile patients by determining their level of risk dependent on the complexity of their disease type or needs.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed. We saw that actions had been agreed to implement service improvements and manage delivery challenges to the practice's population.

Longer appointments were available for patients who needed them, for example those who were supported by an interpreter and those with long term conditions. This also included appointments with a named GP or nurse.

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

The practice had implemented suggestions for improvements and made changes as a consequence of feedback from the Patient Participation Group (PPG). Some examples of this included: new and more comfortable seating in the waiting area, a new webmedia screen to provide patients with relevant information and a new patient call system. The front doors of the practice were also replaced which had improved access into the building, particularly for patients who used a wheelchair and mothers with pushchairs. This was carried out as a result of patient feedback.

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

The practice provided a female health clinic and used in house expertise to reduce unnecessary referrals to other services. The practice provided chlamydia screening packs to enable young people to carry out self referrals if required.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. For example with palliative care co-ordinators and district nurses. The practice also worked closely with the Mayfair service at the local community centre next door which offered a service to support patients to improve their independence in their own home. As part of this the practice referred patients to access this service.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. For example those with a learning disability and carers. The practice had access to translation and interpreting services and longer appointments were provided for those patients who were supported by an interpreter.

Female GPs worked at the practice and were able to support patients who preferred to have a female doctor. This reduced any barriers to care and supported the equality and diverse needs of the patients.

There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a disabled toilet and wheelchair access to the practice for patients with mobility difficulties. All treatment and consulting rooms for patients were located on the ground floor.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Comprehensive information about appointments was available to patients on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Appointments were available from 8:30am to 6:00pm on weekdays, including lunchtimes, to provide an opportunity for working patients to have an appointment around their work commitments. Staff told us that they had previously carried out extended opening hours starting at 7:00am. As uptake of these appointments was low from people of working age, the practice now provided early appointments starting at 8:00am on a Monday and Friday each week.

The practice had an online booking system which patients told us was easy to use. The practice provided text message reminders for appointments and test results for those patients who had consented to this. There were also telephone consultations for patients where appropriate.

Patients were extremely satisfied with the appointments system. Comments received from patients showed that those in urgent need of treatment had been able to make appointments on the same day of contacting the practice. The national GP survey for 2013 showed that 86% of respondents found it easy to get through to the practice by phone and 88% of respondents usually waited 15 minutes or less after their appointment time to be seen. This was above the CCG regional average of 66%. The survey also showed that 99% of respondents said that the last appointment they got was convenient which was also above the CCG regional average of 94%.

The patient participation group (PPG) at the practice carried out an annual survey. For 2013/2014 the PPG had designed and carried out a survey to establish the ease of access to doctors and nurses for patients and the helpfulness of receptionists. We saw that 506 surveys were completed and 93% of patients who responded said they saw the doctor of their choice within ten days and were able to see a doctor on the same day when they needed to. The survey also showed that 92% of respondents found it easy to talk to the practice on the telephone and 97% of patients considered the receptionists to be helpful.

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

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. A complaints leaflet was available in the waiting area and details about how to make a complaint was set out on the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last twelve months and found each were handled in a satisfactory and timely manner. The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a mission statement which set out its vision to "strive to provide the best possible high quality healthcare for all". This included a number of aims such as: "to respect every patient as an individual, be honest and open with our patients and to provide a professional service at all times".

We spoke with the practice manager about the values/aims and they confirmed that these were discussed at induction, at meetings with staff and during appraisals. We spoke with twelve members of staff and they all knew or demonstrated the values of the practice and what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff from any computer within the practice. We looked at eight of these policies and procedures and saw that they had been reviewed and were up to date. We spoke with staff about how they accessed the policies. They told us and we saw that accessing the documents was time consuming and that they were not always easy to find.

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

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF rewards practices for providing quality care and helps fund further improvements. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was monitored and action was taken to maintain or improve outcomes if required. For example we saw that the practice had taken action to try to reduce increased attendance levels of elderly from their patient group at the local accident and emergency department. The practice had signed up to be part of the Clinical Commissioning Group's (CCG) Care Home Advanced Scheme which had been developed to identify those patients who were at risk of being admitted to hospital. This scheme provided a new approach to support these patients through a process of joint assessment and care planning.

The practice had completed a number of clinical audits, for example a medication audit and an audit of patients receiving anticoagulation therapy. The audits identified the expected improvements from changes to practice and a follow up audit had either been carried out or was planned at a later date to assess the progress and impact for patients.

The practice had some arrangements for identifying, recording and managing risks, however these needed to be further developed to ensure a robust risk management system was in place. For example the fire safety risk assessment and portable equipment testing.

Leadership, openness and transparency

We saw that there was a leadership structure which had named members of staff in lead roles. For example the senior nurse at the practice was the lead for infection control, one GP was the lead for minor surgery and another led on female health care and family planning. Other GPs within the practice led on diabetes, asthma, GP registrar training and mental health conditions. We spoke with twelve members of staff and they were all clear about their own roles and responsibilities. Staff told us that they all worked as part of a team

GPs at the practice had a daily meeting to share information and to discuss any clinical issues prior to carrying out home visits. The practice held a number of meetings which were minuted. These included business meetings, a staff meeting every month, meetings with other professionals. These included a meeting about frail and elderly people and another to discuss vulnerable families with the health visitor. Staff told us that they felt the meetings were useful and they received copies of minutes which they signed to confirm they had read. Staff told us that there was an open culture within the practice and they had the opportunity and felt able to raise issues at any time with the partners and practice manager.

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

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

The practice gathered feedback from patients through patient surveys, suggestion box comments and complaints

Are services well-led?

Good

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

received. We looked at patient surveys and complaints made by the patients. We saw that positive action had been taken in response to these. For example the front doors of the practice had been replaced to improve access into the building, particularly for patients who used a wheelchair and families with pushchairs.

The practice had an active patient participation group (PPG) which met every four to six weeks and was supported by the assistant practice manager. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. The PPG also held public meetings and one of the practice GPs always attended these. At the public meetings a GP from the practice and the assistant practice manager delivered presentations to the audience on particular areas of interest. For example new initiatives for patients with dementia and general access to the practice.

We saw that the PPG at the practice carried out an annual satisfaction survey for patients. We saw that the most recent survey was completed to establish the ease of access to doctors and nurses for patients and the helpfulness of receptionists. We saw that 506 surveys were completed and 93% of patients who responded said they saw the doctor of their choice within ten days and were able to see a doctor on the same day. The survey also showed that 92% of respondents found it easy to talk to the practice on the telephone and 97% of patients considered the receptionists to be helpful. We saw that the results of this survey and actions agreed were available on the practice website.

The chair of the PPG told us that the group had been trying to recruit members from all age groups and backgrounds in order for them to be representative of the practice population. The PPG had carried out a number of initiatives to raise the profile and increase the membership of the group. This included speaking to patients in the practice waiting area and providing an information stand in one of the local supermarkets to attract more interest in the PPG.

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

Management lead through learning & improvement

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

The practice was a training practice for medical students. We saw evidence of feedback from medical students at a well known medical school about the practices they had received training during the last academic year. Out of 25 general practices, the Church Stretton Medical Practice came top in the student feedback which included their experiences of assessments and feedback, clinical exposure, the quality of the GP as a teacher and the practice as a place to learn.

The practice had completed reviews of significant events and other incidents and shared them with staff at meetings to ensure the practice improved outcomes for patients. For example, a patient and child from out of area attended the practice and the staff recognised that the child was very ill. Prompt action was taken by the reception staff and practice nurse and an ambulance was called. We saw that this serious incident was handled well by the staff and discussed at a staff meeting. The actions taken in response to the emergency were also reinforced at a training session for staff.