Craven Arms 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 Craven Arms Medical Practice on 15 June 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, with the exception of those relating to recruitment checks.
- 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 said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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

- Review significant events over time to identify any themes or trends.
- Consider recording information about children with protection plans within the parent /guardian electronic patient record.
- Ensure all staff who act as chaperones have received appropriate training.
- Carry out a risk assessment to ensure the safety of confidential information within the practice.
- Carry out a risk assessment to ensure the safety of medicine storage in the reception area.
- Ensure all necessary pre-employment checks are obtained and appropriate information kept on file.
- Complete the process of obtaining Disclosure and Barring Service checks for clinical staff.
- Complete the process of carrying out risk assessments or Disclosure and Barring service checks on non-clinical staff who act as chaperones.
- Ensure patient confidentiality is maintained at the reception hatch.
- Share the practice's aims with staff and patients.
- Develop a business plan to support delivery of the practice aims and any future developments.

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. The practice had a system in place for reporting, recording and monitoring significant events, although these were not reviewed over time to identify trends or themes. 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, with the exception of those relating to recruitment checks. Not all staff had completed training on safeguarding children and vulnerable adults and chaperoning (where appropriate). However there was a training plan in place to address this. 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 at or above 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 worked with other health care professionals to improve patient outcomes. Regular multi-disciplinary meetings were held and information was recorded directly in patient notes. Staff were receiving training appropriate to their roles and any further training needs was identified through appraisals and personal development plans for staff. Effective systems were in place in respect of information sharing with other services and promoting health promotion and prevention.

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. This was reflected in the data we looked at which showed positive patient feedback in relation to involvement in decisions about their care and treatment. The practice had 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.

Summary of findings

We saw that staff were respectful and polite when dealing with patients, and maintained confidentiality. Views of external stakeholders such as care home managers 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 with a GP of choice, there was continuity of care and urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. However the practice aims had not been shared with the staff and patients. A business plan was not in place support delivery of the aims and any future developments. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. 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 had introduced the Compassionate Communities Project, which identified the isolated and lonely patients in the older population and matched them with volunteers to provide social interaction and support. It was responsive to the needs of older people and offered home visits as required. The practice identified if patients were also carers, and information about 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 structured review to check that their health and medication needs were being met. 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 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 structured review to check that their health and medication needs were being met. 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.

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. Although the practice did not offer extended hours,

Summary of findings

appointments were available up to 6pm and telephone consultations could be arranged. 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. 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, a number of which were provided at the practice. Patients requiring for psychological support could be referred to the visiting counsellor. The local memory team provided support for patients and carers on a monthly basis. The community mental health nurse held fortnightly assessment.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of the inspection. Patients were satisfied with the service they received at the practice. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We reviewed the two patient comments cards from our Care Quality Commission (CQC) comments box. We saw that the majority of comments were positive. Patients said they felt the practice offered an excellent service and staff were understanding, accommodating and professional.

We looked at the national patient survey published in January 2015. The survey found that 95% of patients described their experience of the practice as good. The results showed that 88% of patients would recommend the practice to someone new to the area, which was higher than the Clinical Commissioning Group average of 82.8%.

Areas for improvement

Action the service SHOULD take to improve

Review significant events over time to identify any themes or trends.

Consider recording information about children with protection plans within the parent /guardian electronic patient record.

Ensure all staff who act as chaperones have received appropriate training.

Carry out a risk assessment to ensure the safety of confidential information within the practice.

Carry out a risk assessment to ensure the safety of medicine storage in the reception area.

Ensure all necessary pre-employment checks are obtained and appropriate information kept on file.

Complete the process of obtaining Disclosure and Barring Service checks for clinical staff.

Complete the process of carrying out risk assessments or Disclosure and Barring service checks on non-clinical staff who act as chaperones.

Ensure patient confidentiality is maintained at the reception hatch.

Share the practice's aims with staff and patients.

Develop a business plan to support delivery of the practice aims and any future developments.

Craven Arms Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission lead inspector. The lead inspector was accompanied by a GP 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 Craven Arms Medical Practice

Craven Arms Medical Practice is located in Shropshire and provides primary health care to patients living in Craven Arms 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 and minor surgery. It also offers a phlebotomy service. Phlebotomy is the taking of blood from a vein for diagnostic tests.

A team of two GP partners, one salaried GP, three practice nurses, two phlebotomists and three pharmacy dispensers provide care and treatment for approximately 3893 patients. There is also a practice manager, six receptionists and administrative staff. There are two male and one female GP.

The practice is open between 8.30am until 1pm and 2pm until 6pm Monday, Tuesday, Thursday and the second and fourth Wednesday of each month. The practice opens later, 9.30am on a Friday, and closes earlier, 5 pm on the first and third Wednesday of each month. The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to the out of hours service, 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

Prior to our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS Shropshire Clinical Commissioning Group, Healthwatch and NHS England Area Team.

We carried out an announced visit on 15 June 2015. During our inspection we spoke to a range of staff including two GPs, a practice nurse, and the practice manager, dispensary and reception staff. We spoke with eight patients who used the service about their experiences of

Detailed findings

the care they received. We reviewed two patient comment cards sharing their views and experiences of the practice. We spoke with the chairperson of the patient participation group and representatives from two local care homes.

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

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

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

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

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. Staff told us they were encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

We saw there were safety records and incident reports for nine years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of two significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice clinical meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff including receptionists and nursing staff knew how to raise an issue for consideration at the meetings. A dedicated meeting to identify trends and themes from past significant events and complaints was not held.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw evidence that information about significant events was used to make changes to reduce the risk of future errors. All significant events were reported directly to the practice manager. For example, a series of medicine errors had been identified which tended to occur when dispensary staff were distracted by phone calls from patients or district nurses. This was resolved by a joint meeting with the district nurses and patients no longer make phone calls for repeat prescription requests. This had resulted in reduced calls into the dispensary and reduced medicine incidents. We tracked two other incidents and saw evidence of action taken as a result and the outcome. One incident related to a patient with high blood pressure presenting with diarrhoea that did not improve with medication. Blood tests were taken which showed abnormal results. We saw that the incident forms recorded the analysis of the incident, action plan and follow up and that the incident had been discussed at the clinical meeting.

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. Although staff had not attended any recent training, they 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, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Staff were currently working through an e-learning training programme on safeguarding.

The practice held registers for children at risk, and children with protection plans were identified on the electronic patient record. We noted that the information was not always recorded on the parent / guardian notes as well. 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 practice worked with other services to prevent abuse and to implement plans of care. Monthly meetings were held between the GPs, practice nurses and health visitor to discuss safeguarding issues as well as any mothers were required additional support. All information was recorded directly on the electronic records.

Good

Are services safe?

We saw that due to the lack of storage space confidential information was stored in a locked cupboard accessed by staff not directly employed by the practice. A risk assessment was not available to ensure the safety of this confidential information within the practice.

There was a chaperone policy in place. (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). Not all staff who acted as chaperones had received training but when questioned, clearly understood their responsibilities when acting as chaperones. Staff were currently working through an e-learning training programme on chaperoning. Staff undertaking chaperone duties had not received Disclosure and Barring Service (DBS) checks and non-clinical staff did not have a risk assessment in place. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice manager informed us following the inspection that risk assessments had been completed for all non-clinical staff, and DBS checks were being requested for clinical staff and should be completed by the end of July 2015.

Medicines management

We found that medicines in the dispensary and medicine refrigerators were stored securely in a clean and tidy manner and were only accessible to authorised staff. Medicines and in particular vaccines requiring cold storage were stored securely in a locked refrigerator. Daily temperature records were being documented which were all within safe temperature ranges for medicine and vaccine storage. Medicines were purchased from approved suppliers and the dispensary maintained an electronic list of the quantities of medicines in stock. Processes were in place to check medicines were within their expiry date.

We observed returned and unwanted medicines stored in an open top clinical waste bin in the main reception area, due to the lack of storage space in the dispensary. We were told that practice staff were always present or the room was locked and secure. However, there was no risk assessment available to ensure the safety of medicine storage in the reception area.

Dispensing errors were recorded and systems were in place to action any medicine recalls. We observed that all dispensed prescriptions were double checked by two dispensary staff. This helped to reduce the risk of medicine errors. We found an open and transparent culture of reporting errors with lessons learnt to protect patients from harm.

Blank prescription forms were stored securely and were tracked through the practice. We saw that they were stored in a secure cupboard and only accessible by dispensary staff. We saw records of serial numbers to identify prescription pads so they could be tracked once they were removed from the cupboard.

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 dispensary staff. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. The total quantities of controlled drugs stored were documented in a controlled drugs register. We checked these quantities which were accurate. There were suitable arrangements in place for the destruction of controlled drugs.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence. We were told that dispensary staff were also able to contact a local community pharmacist for any advice or specialist knowledge on medicines.

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.

One of the practice nurses was the lead for infection control within the practice. We saw that the infection control lead had attended external infection prevention and control

training. Other staff were currently working through an e-learning training programme on infection control. An infection control audit had been carried out in October 2014 by the local Clinical Commissioning Group (CCG). The practice achieved an overall score of 75% and produced an action plan to address the issues identified. A follow up visit was made in March 2015 and the action plan had been completed.

Reasonable steps to protect staff and patients from the risks of health care associated infections had been taken. Staff had received relevant immunisations and support to manage the risks of health care associated infections. Spillage kits were available to manage any spillage of bodily fluids. A legionella risk assessment had been completed in June 2014 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

We saw that staff had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and thermometers.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The majority of staff including the practice nurses had worked at the practice for many years. This was before the current requirement to obtain the pre-employment recruitment checks, including checks through the Disclosure and Barring Service (DBS) were introduced. We looked at a staff file for a newly recruited member of reception staff and the community care co-ordinator (who had not yet commenced their employment). Records we looked at did not contain evidence that all appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification and full employment history.

The practice had not completed checks through the DBS or risk assessments for staff who had been employed at the practice prior to registration with the Care Quality Commission. DBS checks help employers make safer recruitment decisions and identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice manager informed us following the inspection that risk assessments had been completed for all non-clinical staff, and DBS checks were being requested for clinical staff and should be completed by the end of July 2015.

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

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. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (A portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver

Good

Are services safe?

an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

A business continuity plan (known as the disaster recovery plan) was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, unplanned sickness and access to the building. The business continuity plan included important contact numbers for use in the event of the loss of one of these services.

A fire risk assessment had been completed and was reviewed annually. Staff had attended fire awareness training in 2013. Staff were currently working through an e-learning training programme on fire safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). The practice nurse we spoke with told us that they were made aware of any new guidance and it was discussed within the clinical meetings. We found from our discussions with the GPs and nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease, family planning and dermatology and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

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 97.3% in QOF which was above the local Clinical Commissioning Group average (92.3%) and the national average (94.2%). This practice was not an outlier for any QOF (or other national) clinical targets.

The practice showed us four clinical audits that been undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. One of the GPs had carried out an audit to see whether cardiovascular risk assessments had been completed for patients with Rheumatoid Arthritis (RA). Patients with RA are at greater risk of cardiovascular death. The first audit identified that 28 patients had a diagnosis of RA and of these, 13 (44%) of patients had a cardiovascular risk assessment in place. Patients were invited to attend so that a cardiovascular risk assessment could be carried out. A second audit demonstrated that 94% of patients with RA had a cardiovascular risk assessment in place, and 56% of patients had been prescribed cholesterol lowering medication and 34% prescribed antihypertensive medication (to lower blood pressure). This demonstrated an increase in the detention of patients with increased cardiovascular risk, enabling appropriate treatment to be commenced.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. We were shown how dispensary staff checked that all repeat prescriptions had been reviewed and signed by a GP before they were given to the patient. Any changes made to patients' repeat medicines, for example following a discharge from hospital, were either undertaken by a GP at the surgery or by the dispensary staff which was always clinically checked by a GP before it was dispensed. This ensured that patient's repeat prescriptions were always clinically checked. The practice nurses 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. For example, we saw that 95% of patients with diabetes, 96% of patients with COPD and 90% of patients with asthma had received an annual medication review in the last 12 months.

The practice held monthly multidisciplinary team meetings to discuss patients with complex problems, for example those with end of life care needs or receiving care from the community nurses. Weekly meetings with the community nurses were held to discuss any patients receiving their care. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had received training appropriate to their roles, and had protected learning time for ongoing training. Continuing professional development for nurses was monitored through appraisals, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice. We noted a good skill mix amongst the GPs with two having an additional diploma in sexual and reproductive medicine and one with a diploma in dermatology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

The nursing team were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical smears, and smoking cessation. Those with the extended roles of providing annual health reviews for patients with long term conditions such as asthma and diabetes were able to demonstrate that they had appropriate training to fulfil these roles. Each nurse had a lead role for long terms conditions and were supported by the GPs with the management of these patients. Training records supported that the phlebotomists (staff who take blood samples) and the dispensary staff had appropriate training and / or additional qualifications to support them in their role.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, and the out-of-hours GP services 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 GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We spoke with the representatives of two local care homes. They told us they had a good working relationship with the practice, and the GPs visited the service to discuss results and potential changes to care with the patient and the staff. Regular meetings were held with the district nurses, hospice outreach palliative care nurse and health visitor to discuss patients.

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

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. 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. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice referred to the policy provided by the local NHS organisation to support staff who were required to obtain consent. (This policy was out of date as it was written by the primary care trust, which is no longer in operation).

Good

Are services effective?

(for example, treatment is effective)

Not all staff had received training on the Mental Capacity Act 2005. Staff was currently working through an e-learning training programme on the Mental Capacity Act 2005.

There was a practice policy for documenting consent for specific interventions. For example, for all invasive procedures written consent from the patient was obtained and scanned on to the patient's notes. Staff told us that GPs had sought the patient's consent to certain decisions, for example, 'do not attempt cardiopulmonary resuscitation' (DNACPR) care plans. They told us the appropriate paperwork was completed. We spoke with representatives from one local care home who told us that GPs were supporting them to discuss end of life care and the DNACPR care plans with the patient and their families.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

Health promotion and prevention

It was practice policy to ask all new patients registering with the practice if they wanted to make an appointment to see the GP, although patients on regular medicines were routinely booked for an assessment and review of their medicines. NHS Health Checks were offered to patients between 40 to 75 years. During 2014/2015 429 patients were invited by letter and 53 attended.

The practice provided a range of support to enable patients to live healthier lives. Examples of this included, travel advice and vaccinations, in house smoking cessation and help to slim programmes. During the previous 12 months 525 patients had received smoking cessation advice. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The nursing staff told us they discussed promoting a healthy lifestyle with patients when they carried out reviews for patients with long term conditions. Leaflets on health promotion and support groups were available in the waiting room.

The practice offered sexual health and family planning advice and support, including emergency contraception. Chlamydia screening was available for patients aged 16 to 24 years and 28 patients had been screened during the previous 12 months.

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 all immunisations was in line with or above the average for the local CCG, and there was a clear policy for following up non-attenders.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability or mental health need and these patients were offered an annual physical health check.

The practice's performance for cervical smear uptake was 78.1%, which was slightly below the national target of 80%. There was a policy to send reminders for patients who did not attend for cervical smears. Eligible patients had been referred to screening for cancers. For example, 108 patients had received breast screening and 389 patients had received screening for bowel cancer.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with eight patients during the inspection and collected two Care Quality Commission (CQC) comment cards. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments included that the practice offered an excellent service and staff were understanding, accommodating and professional.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 128 replies to the national patient survey carried out during January-March 2014 and July-September 2014 and a survey of 69 patients undertaken by the practice, report dated 2015. The practice also received comments from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The evidence from all these sources showed patients were satisfied with how they were treated and that this was generally with compassion, dignity and respect. For example, data showed that 95% of patients rated their overall experience of the practice as good, which was higher than the Clinical Commissioning Group average (89.7%) and the national average (85.2%). The survey showed that 95.4% of patients felt that the doctor was good at listening to them, and 97.5% said the GP gave them enough time. Both of these results were above the local CCG average and national average. The survey showed that 92.7% of patients felt that the nurse was good at listening to them, and 91.6% said the nurse gave them enough time. Both of these results were above the local CCG average and national average.

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

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 hatch and was shielded by glass partitions which helped keep patient information private. Due to the layout of the building confidentiality was more difficult to maintain when patients used the reception hatch. This area was separate to the waiting room but was quite small, and there was the potential for patients to overhear private conversations between patients and reception staff. The practice may wish to consider introducing a system to only allow one patient at a time to approach the reception desk.

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. One patient commented on their comment card that the GPs were good at listening to and treating patients.

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 85% of practice respondents said the GP involved them in care decisions and 95.2% felt the GP was good at explaining treatment and results. The results were similar for the nurses, with 91.6% of practice respondents said the nurse involved them in care decisions and 89.9% felt the nurse was good at explaining treatment and results. All of these results were above the local CCG and national average.

Staff told us that English was the first language for the majority of patients registered at the practice. Staff told us that translation services were available for patients who did not have English as a first language.

We saw that the practice took a proactive approach to identify patients who were assessed as most vulnerable, or who had additional needs due to their medical condition. For example, those with mental health difficulties or dementia, complex health needs or end of life care. The practice had identified those patients most at risk of admission and individual care plans had been developed and agreed for these patients.

Good

Are services caring?

The practice worked closely with external professionals (for example the district nurses and hospice outreach palliative care nurse) and met monthly to discuss patients with complex health needs or end of life care needs. The practice also met weekly with the district nurses to review patients receiving their care. We saw systems were in place to ensure patients with a long term condition received a health review at least annually. This included patients for example with coronary heart disease, diabetes, chronic obstructive pulmonary disease (chronic lung disease) and asthma.

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, 94.7% 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 87.7% and national average of 82.7%. The results were similar for the nurses with a score of 86.9% compared to the local CCG (82.2%) and national average (78%). 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 and the practice website also told patients how to access a number of support groups and organisations. There was a patient information file available in the waiting room with contained a wide range information about support available for patients. The practice's computer system alerted staff if a patient was also a carer. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided cared for. The practice offered all carers a seasonal 'flu vaccination.

The Citizen's Advice Bureau (CAB) held weekly sessions at the practice. The CAB assisted patients to complete forms to access benefits and support that they were entitled to. A NHS funded counsellor held weekly clinics at the practice for patients who had been referred for psychological support. The local memory team held a monthly clinic at the practice. Staff told us this had improved communication between the practice and the memory clinic. It also meant that carers' support needs could be identified at the same time as the patient, enabling both to receive the support they needed.

The practice had introduced the compassionate communities (Co-Co) project. This was a befriending project which involved volunteers visiting isolated or lonely patients identified by the GPs. For example, a patient with dementia received weekly visits from a volunteer. The patient benefited from the social interaction and going out to visit places, whilst their carer benefited from some time to themselves.

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 actively engaged in local Clinical Commissioning Group (CCG) projects. The practice manager was involved in the long term conditions community subgroup and steering group. One of the innovations from the community development group was the role of the community and care co-ordinator. Their role was to provide a signposting service to patients for health, social care and voluntary sector organisations. The practice manager and the senior partner also attended the monthly local CCG meetings and reported back to the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). 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. Following comments from the PPG and patient survey, information about the different type of appointments was clearly displayed in the waiting room.

We spoke with representatives from two local care homes. 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. They said that the GPs involved the patients and families in decision making around end of life care.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some people faced in accessing or using the service. For example, patients with a learning disability and people accommodated in the local care homes. Staff told us that these patients were supported to register as either permanent or temporary patients. The practice had a policy to accept any patient who lived within their practice boundary irrespective of ethnicity, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

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. Patients had a choice of seeing a male or female GP.

The practice provided equality and diversity training through e-learning. The staff team were currently working through the e-learning training programme.

The premises and services had some adaptations to meet the needs of people with disabilities. The practice was situated on the ground and first floors of the building, with services for patients on both floors. The waiting area on the ground floor was large enough to accommodate patients with wheelchairs and prams. There was step free access to the main entrance with automatic doors, although the door through to the waiting room was not. Access to the first floor was via stairs. Patients were informed that the GP who was based on the first floor would see patients in one the consulting rooms on the ground floor. Disabled toilet facilities were available on the ground floor.

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. Information about the different types of appointments available was also on display in the waiting room. The contact telephone arrangements for the out of hours service was in the practice leaflet and on the website. Telephone calls made to the practice when it was closed were automatically diverted to the out of hours service.

The practice was open between 8.30am until 1pm and 2pm until 6pm Monday, Tuesday, Thursday and the second and fourth Wednesday of each month. The practice opened later, 9.30am on a Friday, and closed earlier, 5 pm on the first and third Wednesday of each month. Routine appointments with the GP were pre-bookable up to a week in advance and up to two weeks in advance with the practice nurses. Same day and urgent appointments were available and any patient who requested to be seen

Good

Are services responsive to people's needs?

(for example, to feedback?)

urgently would be seen the same day. Appointments also included five routine and two urgent telephone consultations with each GP. Consultations are available between 9am and 12 noon and 3pm and 5.30pm each day except Wednesday, when the consultations are available until 5pm. The practice had chosen not to offer any extended hours.

Patients were satisfied with the appointments system and told us they could always get an appointment when they needed one. These comments were similar to those made on the comment cards. We observed the reception staff speaking with patients and make appointments. Appointments were available for the day of the inspection and during the week of the inspection. The data from the national patient survey carried out during January-March 2014 and July-September 2014 (published January 2015) indicated that 96.2% of respondents were able to get an appointment or speak to someone last time they tried, which was higher than the local CCG (89.3%) and national average (85.4%). We saw 90% of respondents said their experience of making an appointment was good, which was above the local CCG (81.2%) and national average (73.8%). Patients did comment that occasionally they were not seen at their appointment time. This was reflected in the data from the patient survey, where 45% of respondents said they usually wait 15 minutes or less after their appointment time to be seen. This was below both the local CCG (65.3%) and national average (65.2%). However patients spoken with told us they didn't mind waiting, as it meant that the GPs did not rush patients who needed more time on that occasion.

The practice had access to a range of services to support patients with mental health needs. Patients could be referred to the counsellor for psychological support. Clinics with the counsellor were held every week at the practice. The local memory team held clinics at the practice every month. The community psychiatric nurse held an assessment clinic at the practice every two weeks. The benefit for patients and carers was that they were being seen in an environment that they were familiar with.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Patients were made aware of how to complain through a complaints poster in the waiting room and information in the practice leaflet and on the website. None of the patients we spoke with had any concerns about the practice or had needed to use the complaints procedure.

We found that there was an open and transparent approach towards complaints. The practice had received two written complaints during 2014 – 2015. We saw that the practice recorded these complaints and actions were taken to resolve the complaint as far as possible. The practice had a number of ongoing complaints that were being managed by the Medical Defence Union (MDU). The MDU is a protection organisation for medical, dental and healthcare professionals.

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. The aims of the practice were included in the statement of purpose. They included offering each patient the best quality of care to meet individual needs and to respect every patient as an individual. It was clear when speaking with the GPs and the practice staff that they shared these aims and were committed to providing high quality care that met the needs of the practice population. Written information about the aims of the practice was not shared with patients and staff. However, the practice did not have a business plan in place to support delivery of the practice aims and any future developments.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically and in paper form. Review dates were included in the policies. We saw that policies had been reviewed. A number of policies had been developed by previous NHS organisations, for example the Primary Care Trust and the practice was awaiting the updated policy when developed by the local Clinical Commissioning Group (CCG)

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 nine 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 held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract the practice used the Quality and Outcomes Framework (QOF) to measure their performance. 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. The QOF data for this practice showed it was performing above the local CCG and national average. We saw that QOF data was discussed at the clinical staff meetings.

The practice carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, carrying out additional health checks on patients diagnosed with rheumatoid arthritis. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example legionella risk assessment. The practice updated the risk log at least annually as well as when required due to a change in circumstances.

Leadership, openness and transparency

We saw that a range of staff meetings were held weekly or monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or with the practice manager. We looked at the minutes from the various meetings. The meetings were used to discuss a range of topics, including ongoing monitoring of performance, delivery of enhanced services and feedback from any projects or local initiatives.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as the recruitment and selection policy which were in place to support staff. The policies were all stored electronically and in paper form and staff we spoke with knew where to find these policies if required.

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), surveys, NHS Friends and Family Test and complaints received. It had an active PPG, although the chairperson recognised that the group did not include representative from all of the various population groups, as the majority of members were retired. The PPG met with the practice manager on a monthly basis and supported the practice when they had carried out satisfaction surveys. The practice manager showed us the analysis of the last patient survey, which

Are services well-led?

Good

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

was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website and on display in the practice. We spoke with the chairperson of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had a good working relationship with the management.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. They told us that they received an annual appraisal and there was a policy in place to support this. They confirmed the practice was very supportive of training and that they had protected learning time three times a year.

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 clinical meetings.

The practice was actively engaged with the local Clinical Commissioning Group (CCG) and therefore involved in shaping local services. For example, the practice manager was involved in the long term conditions community subgroup and steering group. One of the partners and the practice manager also attended the locality meetings. This was beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted. Both of the GP partners were involved with the local out of hours service Shropdoc.