# Stirchley 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 Stirchley Medical Practice on 14 September 2016. Overall the practice is rated as good.

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

- The practice operated a named GP patient list, providing continuity of care for patients. Patients were offered appointments with their usual GP for ongoing issues.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients told us they were able to get an urgent appointment through the triage system.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Information about services and how to complain was available and easy to understand.
- Risks to patients were assessed and well managed.
- 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.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw an area of outstanding practice:

- The practice recognised that the practice population was younger than average and the need to actively manage the care of young people and families, especially in relation to contraception and unplanned

# Summary of findings

pregnancies. The practice offered same day access was offered for emergency contraception and a card system was used to identify the reason for the visit and facilitate easy access. Condoms were also provided by the practice. The number of teenage pregnancies had fallen from 23 in 2013 to 15 in 2015.

There are areas of practice where the provider should make improvements.

The provider should:

- Make patients aware that translation services are available.

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

**Are services effective?**

Good

The practice is rated as good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to the national average.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice in line with or higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

# Summary of findings

- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- The practice offered a range of enhanced services including minor surgery, vasectomies and spirometry (a test to see how well a patient can breathe).
- The practice co-hosted services for diabetic patients at the same time as the diabetic clinics, for example, diabetic eye screening and podiatry and access to the diabetic specialist nurse, so patients only needed one appointment.
- Patients told us on the day of the inspection they were usually able to get appointments, but not always with their usual GP.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

**Are services well-led?**

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

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- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

# Summary of findings

## The six population groups and what we found

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

### Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population including their registered patients in care homes.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The frailest two per cent of the practice patients had a hospital admission avoidance care plan in place which highlighted their needs and wishes and was reviewed regularly.
- The practice worked closely with an Age Concern Care Navigator. Care Navigators assist patients who may feel lonely or isolated, have little local support, have been recently bereaved or who wish to find out about services which may be available to them. They can help put in place support or find activities provided by voluntary and statutory services.

### People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice maintained registers of patients with long term conditions. Patients were offered a structured annual review to check their health and medicines needs were being met.
- Weekly clinics were held for patients prescribed high risk medicine, whereby the patient attended for blood monitoring and collection of their prescription. These medicines were not able to be ordered as a repeat prescription without blood monitoring. The practice offered daily drop in clinics for blood monitoring for patients prescribed warfarin (a blood thinning medicine).
- Longer appointments and home visits were available when needed.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

# Summary of findings

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people.

- The practice recognised that the practice population was younger than average and that they needed to actively manage the care of young people and families.
- There were systems in place to identify and follow up children who were at risk, for example families with children in need or on children protection plans. One member of staff was responsible for maintaining the register and ensured that all family links were identified on the electronic patient records.
- The practice had reviewed teenage pregnancy rates and had actively worked towards reducing the numbers. The number of teenage pregnancies had reduced from 21 in 2013 to 15 in 2015.
- Same day access was offered for emergency contraception and a card system was used to identify the reason for the visit and facilitate easy access. Condoms were also provided by the practice.
- The practice held a 'new mums' clinic every week, and new mothers were invited three weeks after delivery to address post-natal and contraception matters. A contraception review was part of the eight week mother and baby check.
- The practice held child immunisation and child health surveillance clinics on the same day, so families only needed one appointment. Appointments were available outside of school hours and the premises were suitable for children and babies. Same day emergency appointments were available for children. The practice's immunisation rates
- Data from the Quality and Outcomes Framework (QOF) for 2014/2015 showed that 83% of women aged 25-64 had received a cervical screening test in the preceding five years. This was above the national average of 82%. The practice had identified patients who had not attended for cervical screening for more than five years and invited them to attend a consultation.
- The practice offered family planning and routine contraception services including implant/coil insertion.

**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.

# Summary of findings

- The practice offered routine pre-bookable and on the day appointments. The practice operated a fast track nurse surgery, whereby patients with specific conditions were seen by the practice nurses rather than the GPs. Nurse appointments were available from 8am.
- Extended consultation hours were offered on Saturday morning between 8.30am and 12.30pm.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered lunch time walk in clinics for blood monitoring for patients prescribed warfarin (a blood thinning medicine).

**People whose circumstances may make them vulnerable**

Good

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

- The practice identified patients living in vulnerable circumstances because of persistent or transient needs and followed an 'easy access' protocol for these patients.
- Patients were able to register at the practice without identification or proof of address.
- The practice participated in the shared care programme for patients with substance misuse. Patients were seen at the practice by Lead GPs for shared care and a member of the Community Substance Misuse Team.
- The practice worked proactively to engage with patients with 'chaotic lives'. These patients often (but not always) had mental health conditions and misused substances, resulting in the breakdown of family relationships. The practice allocated named GPs and reception staff to these patients. Reception staff received additional training in mental health first aid and the patients were informed to ask for this member of staff when they contacted the practice. Reception staff would contact these patients if they did not attend for their appointments.
- The practice offered longer appointments for patients with a learning disability and annual health checks.
- The practice engaged with families from the travelling community in and around Telford.
- The staff knew how to recognise signs of abuse in vulnerable adults and children. The 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.

# Summary of findings

**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).

- Eighty one per cent of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was similar the national average of 84%.
- The practice carried out advance care planning for patients with dementia.
- Performance for mental health related indicators was comparable to the national average.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Patients had access to a number of local services at the practice to assist them with the management of their mental health, including a memory clinic and counselling services.

# Summary of findings

## What people who use the service say

Results from the national GP patient survey published in July 2016 showed patients felt they were treated with compassion, dignity and respect. Two hundred and ninety two survey forms were distributed and 125 were returned. This gave a return rate of 43%. The practice was average for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 80% of patients said they found the receptionists at the practice helpful compared to the national average of 87%.

Patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were comparable to the local and national averages for the GPs and above the averages for the nursing staff. For example:

- 87% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 83% of patients said the last GP they saw was good or very good at involving them in decisions about their care compared to the national average of 82%.
- 93% of patients said the last nurse they saw was good or very good at involving them in decisions about their care compared to the national average of 85%.
- 97% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 90%.

We invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 35 completed comment cards and these were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and understanding and treated them with dignity and respect.

We spoke with 12 patients and eight members of the Patient Participation Group (PPG) during our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Patients told us on the day of the inspection they were able to get an urgent appointment through the triage system. A number of comment cards also made reference to the challenges of getting through on the telephone and making appointments.

## Areas for improvement

**Action the service SHOULD take to improve**

Make patients aware that translation services are available.

## Outstanding practice

The practice recognised that the practice population was younger than average and the need to actively manage the care of young people and families, especially in relation to contraception and unplanned pregnancies.

# Summary of findings

The practice offered same day access was offered for emergency contraception and a card system was used to identify the reason for the visit and facilitate easy access. Condoms were also provided by the practice. The number of teenage pregnancies had fallen from 23 in 2013 to 15 in 2015.

# Stirchley Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included two GP specialist advisors, a practice manager specialist advisor and an expert by experience.

## Background to Stirchley Medical Practice

Stirchley Medical Practice is registered with the Care Quality Commission (CQC) as a GP partnership provider in Telford, Shropshire. The practice holds a General Medical Services (GMS) contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice area is one of high deprivation when compared with the national and local Clinical Commissioning Group (CCG) area. At the time of our inspection the practice had 13,579 patients. The practice had a higher than average number of patients aged 0 to under 25 years and a lower number than average of patients aged 70 years and over.

The practice staffing comprises of:

- Seven GP partners (four male and three female) and one salaried female GP.
- Seven female practice nurses and two female healthcare assistants.
- A practice manager (managing partner) supported by a personal assistant, a reception manager and data quality manager.
- A reception team, including team leaders and administration clerks.

The practice is open between 8.30am and 6pm Monday to Friday. Extended hours appointments are offered every Saturday morning between 8.30 and 12.30pm. Whenever possible patients are offered appointments with their usual GPs. In addition to pre-bookable appointments that could be booked up to four weeks in advance, on the day appointments are also available for people that needed them. There are two GPs allocated each day to provide a triage service and see patients. Nurse appointments are available from 8am, either through the fast track nurse surgery, or routine for chronic disease management, dressings and health promotion.

The practice has opted out of providing cover to patients in the out-of-hours period. During this time services are provided by Shropdoc.

The practice provides placements for medical students studying at Keele University. The practice is also training practice for GP registrars.

## Why we carried out this inspection

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

# Detailed findings

## How we carried out this inspection

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

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

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

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

Before inspecting the practice we reviewed information we held and asked key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 14 September 2016.

We spoke with a range of staff including the GPs, the nurse manager and practice nurses, a health care assistant, the practice manager, reception manager, data quality manager and members of reception staff. We spoke with patients, members of the patient participation group, looked at comment cards and reviewed survey information. We contacted the local care home to obtain their views on the service provided by the practice.

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

Good

# Are services safe?

## Our findings

### Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. Significant events were discussed at the monthly clinical meeting and reviewed annually. The meetings were minuted so the information could be shared with all staff. The records supported that learning had taken place and become embedded into practice. Staff told us that incidents were also reported on Datix. Datix is an electronic system for reporting incidents and adverse events. The information was shared with the local Clinical Commissioning Group and the local NHS trust.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patient had been prescribed the incorrect dose of medicine by the practice following a hospital consultation. An apology was given to the patient and immediate action taken to undertake blood monitoring and advice sought from the consultant. As a consequence the practice formulary for medicines was updated to reflect the current Clinical Commissioning Group guidance.

The practice had a process in place to act on alerts that may affect patient safety, for example from the Medicines and Healthcare products Regulatory Agency (MHRA). We saw evidence that these had been actioned appropriately by the clinicians.

### Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. Flow charts which clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare were displayed in consulting rooms and treatment rooms. There were lead members of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received the appropriate level of training in safeguarding children and vulnerable adults relevant to their role.
- The practice held registers for children at risk, and children with protection plans were identified on the electronic patient record. One member of staff was responsible for maintaining the register and ensured that all family links were identified on the electronic patient records. The GPs met with the health visitors and school nurses monthly to discuss patients and all meetings were minuted for future reference.
- Notices in the waiting areas and in the consultation/ treatment rooms advised patients that chaperones were available if required. Members of the nursing team acted as chaperones and had been trained for the role and received a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A senior nurse was the infection control clinical lead, and they liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff were provided with infection control training. An infection control audit had been undertaken in November 2015 and we saw evidence that action was taken to address any improvements identified as a result. The practice had also undertaken a post invasive procedures audit, which demonstrated less than one percent infection rate.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).

Good

# Are services safe?

Thorough and effective processes were in place for handling repeat prescriptions which included the review of high risk medicines. Weekly clinics were held for patients prescribed high risk medicine, whereby the patient attended for blood monitoring and collection of their prescription. These medicines were not able to be ordered as a repeat prescription without the blood monitoring. The practice offered lunch time walk in clinics for blood monitoring for patients prescribed warfarin (a blood thinning medicine).

- The practice carried out regular medicines audits, with the support of the local CCG medicines management team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the practice nurses had qualified as an independent prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. They also attended the nurse prescriber meetings held within the locality. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Systems were in place to monitor the ongoing registration of clinical staff with their professional bodies.
- The practice used consistent locum cover on a weekly basis. There was a comprehensive locum pack in place which was practice specific. There was also a checklist in place covering all essential recruitment checks.

## Monitoring risks to patients

Risks to patients were assessed and well managed.

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

## Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training. There were emergency medicines
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The guidance was incorporated into the templates on the electronic system to assist with the assessment of patients with long term conditions.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice achieved 97.7% of the total number of points available (which was 1.6% above the local Clinical Commissioning Group (CCG) average and 2.9% above the national average). Clinical exception reporting was 6.5% (which was 3.5% below the CCG average and 2.7% below the national average). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

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

- Performance in the five diabetes related indicators were comparable to the national average. For example: The percentage of patients with diabetes, on the register, in whom a specific blood test was recorded was 72% compared with the national average of 77%. However, exception reporting for this indicator was below the CCG and national averages.
- For example: The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 72% compared with the national average of 77%. However, the exception reporting rate for this indicator was below the CCG and national averages.
- Performance for mental health related indicators was comparable to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 92% compared to the national average of 88%. The exception reporting rate for mental health indicators was comparable to the CCG and national averages.
- The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months, was 73%, compared to the national average of 75%.
- 81% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was slightly lower than the national average of 84%.

There was evidence of quality improvement including clinical audit.

- We looked at three completed audits undertaken in the previous two years where the improvements made were implemented and monitored. One of these audits looked at the recording of clinical information in febrile children under the age of 5 years in accordance with the recognised guidelines. The first audit cycle showed that clinical information was poorly recorded. It was agreed to set a target of 100% recording of activity level for febrile children. To assist clinicians an electronic recording template was developed, with links to the relevant guidance and early warning 'traffic light' system. The second audit cycle showed that for 36 out 37 children, the activity level was recorded, which was an improvement of 20%.

The practice participated in a number of schemes designed to improve care and outcomes for patients:

- The practice was part of a project which supported two GPs with special interest in elderly care to carry out comprehensive assessments of older patients living in care homes. The project aim was to develop new ways of working to support older patients who lived in care.
- The practice participated in the hospital admission avoidance scheme and had identified 202 patients who were at high risk of unplanned admission. These

Good

# Are services effective?

## (for example, treatment is effective)

patients were identified on the electronic patient record. The care of these patients was proactively managed using care plans and there was a follow up procedure in place for discharge from hospital.

### Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. The practice nurses had attended six training sessions with the diabetic specialist nurses during their protected learning time.
- The staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. The staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example attending immunisation updates. The nurse manager also went to the long term conditions meetings within the locality, which was attended by clinicians from primary and secondary care.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. Staff had protected learning time, either in house or at training events organised by the CCG. All staff had received an appraisal within the last 12 months.
- The practice supported clinical staff to extend their skills and knowledge in order to improve outcomes for patients. The GPs had lead roles for specialisms, for example diabetes, sexual health, mental health, lung disease, heart disease, substance misuse and musculoskeletal. Two clinicians had completed a diploma in diabetes mellitus care and two additional clinicians were due to study towards this diploma. The nursing team were looking to further develop the skills of the health care assistants, in particular around wound care. One of the practice nurses had undertaken additional training in wound care, and was also studying towards the certificate in diabetes care. The health care assistants had received additional training so they could administer certain injectable medicines.

### Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Referrals to secondary care were made through TRAQS, the Telford Referral and Quality Service. The practice was able to access this system and check the progress of each referral.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice had 14 patients who had been identified with palliative care needs and held monthly meetings attended by a GP, practice nurse, the palliative care nurse and community nursing team.

We spoke with a representative from the local care home. They told us they enjoyed a good working relationship with the practice, and the two usual GPs who visited on regular basis were responsive to the needs of the patients. Visits on request were also available. They told us they were informed of the twice weekly visit dates a month in advance, so staff were aware of when patients would be seen. They said having the same two GPs visit provided continuity of care and even though the patients were living with dementia they recognised the GPs and were familiar with them.

### Consent to care and treatment

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

Good

# Are services effective?

## (for example, treatment is effective)

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Staff received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Templates in the electronic patient records assisted staff to asses and record the patient understands.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurses assessed the patient's capacity and, recorded the outcome of the assessment.
- The representative from the local care home told us the GPs were fully involved in advance care planning for patients with dementia, end of life care or complex care needs. They told us they spent time speaking with patients and families to support informed decision making.
- Verbal consent was recorded in the patient's electronic record for the majority of procedures, including immunisations. Written consent was obtained for vasectomies.

### Supporting patients to live healthier lives

Patients who were in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition (disease prevention) and those requiring advice on their diet, smoking and substance misuse. Patients who wished to stop smoking could be referred to an advisor from Quit51. Quit51 is an organisation that provides help and support to smokers who wish to stop smoking or smoke less. The practice participated in the shared care programme for patients with substance misuse, with three of the GP partners participating in shared care.

The practice worked with a health trainer from the Healthy Lifestyle Hub, a service commissioned by the local CCG. The health trainers worked with patients to make changes to their lifestyle.

The practice's uptake for the cervical screening programme was 83%, which was higher than the CCG average of 81% and the national average of 82%. (Exception reporting for cervical screening was 2%, which was 3% below the CCG average and 4% below the national average). The practice offered family planning and routine contraception services including implant/coil insertion. The practice had identified patients who had not attended for cervical screening for more than five years. These patients had been invited in for a consultation to discuss the importance to cervical screening and to carry out the test. Additional appointments were booked as required.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data from 2015, published by Public Health England, showed that the number of patients who engaged with national screening programmes was comparable to the local and national averages:

- 75% of eligible females aged 50-70 had attended screening to detect breast cancer in the last 36 months .This was the same as the CCG average of 75% and above the national average of 72%.
- 55% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer in the last 30 months. This was below the CCG average of 57% and national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to or above the CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95.2% to 98.4% and five year olds from 95.5% to 99%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health assessment for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

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

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

We invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 35 completed comment cards and these were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and understanding and treated them with dignity and respect.

We spoke with 12 patients and eight members of the Patient Participation Group (PPG) during our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published in July 2016 showed patients felt they were treated with compassion, dignity and respect. Two hundred and ninety two survey forms were distributed and 125 were returned. This gave a return rate of 43%. The practice was similar to or above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 80% of patients said they found the receptionists at the practice helpful compared to the national average of 87%.

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were comparable to the local and national averages for the GPs and above the averages for the nursing staff. For example:

- 87% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 83% of patients said the last GP they saw was good or very good at involving them in decisions about their care compared to the national average of 82%.
- 93% of patients said the last nurse they saw was good or very good at involving them in decisions about their care compared to the national average of 85%.
- 97% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 90%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. However, the practice did not display information in the reception areas informing patients this service was available.
- A wide range of information leaflets were available around the practice.

Good

# Are services caring?

### Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 110 patients as carers (0.8%% of the practice list). The practice encouraged patients to inform them if they were also carer through notices displayed around the building, the PPG and when new patients registered at the practice. Information about local support networks, including the carers centre and Age UK, was on display. Carers were offered an annual health check and flu vaccination. Carers could also be signposted to the Care Navigator for advice regarding services in the community. One of the reception staff acted as the Carer Champion for the practice. They maintained the carers register and signposted carers to relevant support organisations.

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

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was involved in the 'Big local', whose vision was to increase and improve existing services to all residents living in the local area. There was a focus on health, children and families and youth.

- The practice operated a named GP patient list, providing continuity of care for patients. Patients were offered appointments with their usual GP for ongoing issues.
- The practice operated a fast track nurse surgery, whereby patients with specific conditions were seen by the practice nurses rather than the GPs.
- The practice visited patients who lived in a local care home on a twice weekly basis. Two GPs carried out the visits to provide continuity of care.
- The practice offered extended hours appointments on Saturday mornings.
- There were longer appointments available for patients with a learning disability or those with complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice worked closely with the Age Concern Care Navigator. Care Navigators assist patients who may feel lonely or isolated, have little local support, have been recently bereaved or who wish to find out about services which may be available to them. They can help put in place support or find activities provided by voluntary and statutory services.
- The practice co-hosted services for diabetic patients at the same time as the diabetic clinics, for example, diabetic eye screening and podiatry and access to the diabetic specialist nurse, so patients only needed one appointment.
- The practice held a weekly chronic wound clinic. One of the practice nurses had undertaken additional training and carried out detailed assessments and developed management plans patients with chronic wounds. The practice had invested in a new Doppler ultrasound machine, which had halved the assessment time, allowing twice as many patients to be seen in clinic. A Doppler ultrasound machine helps clinicians to assess the blood flow through major arteries and veins.
- Patients were able to receive travel vaccinations available on the NHS or were referred to other clinics for vaccines available privately.
- The practice offered minor surgery and vasectomies.

The practice recognised that the practice population was younger than average and the need to actively manage the care of young people and families.

- The practice had reviewed teenage pregnancy rates and had actively worked towards reducing the numbers. One of the GP partners was the lead for sexual health in the practice. Teenage pregnancies were analysed as significant events and reviewed annually. The number of teenage pregnancies had reduced from 21 in 2013 to 15 in 2015.
- Patients were offered same day access to emergency contraception and a card system was used to identify the reason for the visit and facilitate easy access. The practice encouraged the use of long acting contraception, such as implants. Condoms were also provided by the practice.
- The practice held a 'new mums' clinic every week, and new mothers were invited three weeks after delivery to address post-natal and contraception matters. A contraception review was part of the eight week mother and baby check. The aim was to reduce the of mothers becoming pregnancy shortly after giving birth.
- The practice had an immunisation co-ordinator who was responsible for managing the childhood immunisation programme. This member of staff identified children who did not attend for their immunisations and contacted the family to rebook appointments. Child immunisation and child health surveillance clinics were held on the same day, so families only needed one appointment.

The practice also recognised the social needs of the local population and adjustments were made and action was taken to remove barriers for patients who find it hard to use or access services.

- The practice followed an 'easy access' protocol for patients identified as vulnerable because of persistent or transient needs.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- The practice engaged with families from the travelling community in and around Telford.
- Patients were able to register at the practice without identification or proof of address.
- The practice participated in the shared care programme for patients with substance misuse. Patients were seen at the practice by Lead GPs for shared care and a member of the Community Substance Misuse Team.
- The practice worked proactively to engage with patients with 'chaotic lives'. These patients often (but not always) had mental health conditions and misused substances, resulting in the breakdown of family relationships. The practice allocated named GPs and reception staff to these patients. Reception staff received additional training in mental health first aid and the patients were informed to ask for this member of staff when they contacted the practice. Reception staff would contact these patients by text message if they did not attend for their appointments. The practice proactively managed the repeat prescription process for these patients. Post-dated prescriptions were kept at the practice so they weren't misplaced.
- The practice worked closely with TacT (Telford after care team) and the Salvation Army Kip Information Project, local projects for drug rehabilitation and the homeless. Patients who led 'chaotic' lives and homeless patients were 'flagged' with the out of hours service.
- The practice did not remove patients from their list, regardless of their behaviour.

### Access to the service

The practice was open between 8.30am and 6pm Monday to Friday. Extended hours appointments were offered every Saturday morning between 8.30am and 12.30pm. Whenever possible patients were offered appointments with their usual GPs. In addition to pre-bookable appointments that could be booked up to four weeks in advance, on the day appointments were also available for people that needed them. There were two GPs allocated each day to provide a triage service and see patients. Patients received a return telephone call from the triage GP and if they needed to be seen, an appointment was made for them with the urgent care GP allocated to see patients that day.

Nurse appointments were also available from 8am, either through the fast track nurse surgery, or routine for chronic disease management, dressings and health promotion.

Results from the national GP patient survey showed lower than average levels of patient satisfaction with how they could access care and treatment when compared to local and national averages.

- 49% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 75% of patients were very satisfied or fairly satisfied with the practice's opening hours compared to the national average of 80%.
- 57% of patients described their experience of making an appointment as good compared to the CCG average of 70% and national average of 73%.
- 59% of patients stated that the last time they wanted to see or speak with a GP or nurse they were able to get an appointment compared to the national average of 76%.
- 40% of patients felt they didn't normally have to wait too long to be seen compared to the CCG average of 56% and national average of 58%.

However, patients told us on the day of the inspection they were able to get an urgent appointment through the triage system. Four of the comment cards also made reference to the challenges of getting through on the telephone and making appointments.

The practice had reviewed the results from the national patient survey with the local Clinical Commissioning Group in relation to patient access and an action plan devised and agreed to try and address the issues. The results had been compared with the previous two years results to identify any trends over time. The practice had an appointments committee that met on a regular basis to review access to appointments and make changes as required. The practice had recently amended the triage system and introduced the urgent care GP, so the patients were seen close more promptly. For example, patients contacted by the triage GP and booked in to be seen by the urgent care GP during the morning session.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Requests for home visits were managed through the triage system. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

### Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. Information was included in the practice pack on the website and leaflets were available at reception. All of the patients spoken with were aware of the complaints procedure.

We looked at the summary of 27 complaints received in the last 12 months and found they had been satisfactorily handled and demonstrated openness and transparency. The practice carried out a thorough analysis of complaints. A number of complaints related to the appointment system, and staff told us this was constantly under revision, and patients were made aware of the different types of appointments available and the extended hours consultations on a Saturday morning.

# 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. Staff told us all patients were treated with equal respect, regardless of their needs and behaviour and no one asked to leave the practice list.

The partners were aware of the challenges that the practice faced and constantly reviewed the way services were organised to meet these challenges. The practice had held an envisioning session and discussed what the practice should aim to develop over the next five years.

The practice had looked succession planning, in particular around the retirement of GP partners. One partner had given up their role as chair of the local Clinical Commissioning Board following the retirement of a partner in 2016 to enable them to spend more time at the practice. Two new partners had been recruited in anticipation of partners changes in the future.

### Governance arrangements

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

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

### Leadership and culture

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

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

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

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

- Staff told us the practice held regular team meetings. This included meetings for specific groups of staff as well as whole staff meetings.
- The practice held educational meetings for staff every week and outside speakers were invited. For example, the community respiratory team and community mental health services.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Each GP partner was offered a sabbatical of eight to ten weeks every eight years.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Staff described the practice as a caring practice that knew their patients well. They understood that looking after staff was paramount as a cared for team provided a better service for patients. We saw during the inspection that care and compassion form the basis of this practice. There was a GP buddying arrangement in place. Each GP and their buddy met on a regular basis for 10 to 15 minutes to

# Are services well-led?

Good

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

discuss any issues and provide support. Staff also made time to go to the staff room for 'coffee break'. This enabled staff to informally discuss any issues and take time away from their desk/room.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG), through surveys, NHS Friends and Family Test and complaints received. The practice had an active PPG, which met regularly and supported the practice with patient surveys. The practice worked closely with the PPG and viewed their input as a critical friend. In turn the members of the PPG told us they felt listened to and valued. The PPG provided a link with other community groups, such as Telford Town Park, which offered people the opportunity to take part in gardening. The PPG notice board was informative and provided patients with feedback and details of work carried out and completed. The PPG told us the practice had acted on suggestions around the seating in the waiting room, replacing the hand rail and outside lighting and maintaining the garden area around the practice.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. 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 to improve how the practice was run. For example: members of the nursing team expanding their skills and knowledge to enable the practice to meet the needs of the patients.

### Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

The practice was involved in the 'Big local', whose vision was to increase and improve existing services to all residents living in the local area. There was a focus on health, children and families and youth.

The practice was part of a project which supported two GPs with special interest in elderly care to carry out comprehensive assessments of older patients living in care homes. The project aim was to develop new ways of working to support older patients who lived in care.

The practice had been a recent pioneer practice for joint health and social care, working with social services and the council. The 'team around the practice' involved having social workers working at the practice on a daily basis.

The practice was also a training practice for medical students and qualified doctors training to become GPs. At the time of the inspection the practice was supporting one GP register. Three of the GP partners took responsibility for mentoring the medical students and GP registrars.