

Plas Ffynnon Medical Centre

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 

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection 05 November 2014– Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at Plas Ffynnon Medical Centre on 5 December 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The partners had reviewed and increased its workforce and employed additional clinicians with a varied skill mix to help meet the health and social needs of patients and the demand for access to appointments.
- There was a structured programme for staff to receive essential training to enable them to carry out their duties safely. We saw that training had been completed or planned.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it. Patients commented positively on access to same day appointments.
- The practice engaged with the virtual patient participation group (PPG) to meet the needs of their patients. The PPG reported that the practice sent out emails to them to update them on changes within

Summary of findings

the practice. They were less active in requesting feedback or suggestions for surveys from them as members. The members spoken with suggested a more interactive model than is currently in place would be an improvement. All were positive about the care and treatment received from clinical staff.

- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider should make improvements are:

- Review how clinical supervision sessions with the advanced nurse practitioner are recorded.
- Review the system for recording patient safety alerts received and actioned by the practice.
- Engage with the patient participation group to explore improved ways of gaining feedback.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Plas Ffynnon Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, and a practice manager adviser.

Background to Plas Ffynnon Medical Centre

Plas Ffynnon Medical Centre is located in Oswestry and provides primary medical services to patients who live in Oswestry and the surrounding villages. There are 8,972 patients registered with the practice.

The practice has a higher percentage of its practice population in the 65 and over age group than the England average. The practice provides a number of clinics for example asthma, diabetes and heart disease. It offers child immunisations, minor surgery, telehealth dermatology and travel health. The practice also provides a minor injury and phlebotomy service. Plas Ffynnon Medical Centre has a General Medical Services contract.

The practice clinical team includes five GP partners (three male and two female) three salaried GPs, a GP registrar, an

Advanced Nurse Practitioner, four practice nurses, four healthcare assistants one of whom provides the phlebotomy service. The practice is supported by a practice manager, deputy practice manager, a clinical services manager, dispensary staff and reception and administrative staff. The practice employs three cleaners, a caretaker and a community and care co-ordinator. The community and care co-ordinator will proactively identify patients and link them to volunteers and networks within the community. Many of the GPs at the practice also have external roles for example with the out of hours service Shropdoc.

The practice is open from 8.15am to 6pm every weekday and the margins to 6.30pm are covered by the out of hours provider. The practice offers extended hours on Saturday mornings from 8.30am to 10.45am. Plas Ffynnon Medical Centre does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen by the out of hours provider Shropdoc when the practice is closed.

Plas Ffynnon Medical Centre is a postgraduate training practice for GP Registrars. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. Plas Ffynnon Medical Centre is an accredited training practice for nurses working towards a degree in practice nursing. The practice also have staff on an apprenticeship scheme.

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). One of the locum GP's personnel file was less complete. Immediately following the inspection we received confirmation from the practice manager that the required information was in place.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Buddy cover arrangements with staff working additional hours were used to cover those on annual leave or absent through illness. Due to the difficulties experienced with recruiting to GP vacancies, the partners had proactively evolved their workforce and employed additional clinicians with a varied skill mix to help meet the health and social needs of their patients and the demands on the practice. For example, a nurse had completed their Advanced Nurse Practitioner training and taken up this role at the practice since the last inspection. We reviewed the appointment system, spoke with nursing and reception staff, and found that practice nurse appointment availability was at capacity. The practice manager and GP partners advised a new staff member who had been appointed to post had been unable to join the practice until the New Year due to their notice period. They said that the further nurse appointments could be made available if required by releasing the non-urgent appointment slots allocated.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. For example, the practice had adult and child pulse oximeters. The practice reviewed the arrangements against new guidelines, for example, the guidelines for treating acute asthma. Guidelines on treatment were available and kept with the appropriate equipment. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. The clinical system had a built in alert to prompt the consideration of sepsis as a diagnosis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed and administered medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- Arrangements for dispensing medicines at the practice kept patients safe.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. The practice had recorded 25 events/incidents in the past 12 months. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. The practice had recorded 18 complaints in a 12month period an example from learning from one complaint was that following the complaint investigation, the practice apologised and improvements were made to the particular staff members training on information governance. They also recorded compliments and learning from the compliments was also actioned,. For example, staff had responded quickly to a patient showing signs of a stroke and they were advised to call an ambulance immediately, the patient was said to have made an excellent recovery.
- There was a system in place to review, discuss and act on external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety. Following an alert being received, the practice checked to ensure that patients were not affected by the medicines or equipment involved and took appropriate on going action where required. Electronic searches took place that ensured any patients that became at risk were followed up, for example a search of patients on sodium valproate who may become pregnant. Without exploration the actions taken in response to patient safety alerts were not always clear. This system could be further improved with an electronic spreadsheet of the alerts received, any actions taken and by whom and this would act as an aide memoire.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- One of the GP partners had a lead role for technology within the Clinical Commissioning Group (CCG). The practice provided technology and/or equipment to improve treatment and to support patients' independence, for example on-line services.
- Staff advised patients what to do if their condition got worse and where to seek further help and support. For example, patients with asthma, chronic obstructive pulmonary disease (COPD) and diabetes had a personalised care plan. The COPD care plan template included information on how to recognise signs of deterioration and contact details and advice on who to contact.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Patients aged between 40 and 74 were invited for a health check. If necessary, they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12-month period, the practice had offered 692 patients a health check, 497 of these checks had been carried out (72%), 117 patients choose to decline and the remaining 78 did not take up the offer.

- The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines' needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Patients who missed any of their immunisations were monitored and recalled. Uptake rates for the vaccines given were in line with the target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 84%, which was higher than the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way, which took into account the needs of those whose circumstances may make them vulnerable.

Are services effective?

(for example, treatment is effective)

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice hosted the palliative care meetings with a range of professionals to ensure those who were approaching end of life have a more cohesive plan of care across all agencies.

People experiencing poor mental health (including people with dementia):

- 94% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. This was above the national average of, 84%.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was in line with the national average of, 90%.
- The practice specifically considered the physical health needs of patients experiencing poor mental health and those living with dementia. For example, the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption the practice achieved 95%, when compared with the CCG average of 93% and national average of, 91%.
- The practice was a pilot practice for the memory team to run open access clinics at the practice. The aim was to enable patients with possible dementia as well those already diagnosed timely access to early treatment, advice and information.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice had a structured programme of audits that were repeated to benchmark performance. These included 10 clinical audits and five non-clinical audits. Audits were completed for example on the detection and treatment of deep vein thrombosis where it was identified that staff had followed good practice guidelines. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results were 98% of the total number of points available compared with the clinical commissioning group

(CCG) average of 98% and national average of 96%. The overall exception reporting rate was 7% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

- The practice used information about care and treatment to make improvements. For example following a safety alert about a particular medicine used in epilepsy in pregnant women, the practice completed a patient search to ensure those on this particular medicine were not at risk.
- The practice was actively involved in quality improvement activity. The practice regularly reviewed its antibiotic prescribing to ensure they were following appropriate antimicrobial stewardship. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision-making, including non-medical prescribing. Although this took place regularly, there were no written records such as minutes of the clinical supervision sessions that had taken place.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Are services effective?

(for example, treatment is effective)

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.

- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. For example, female patients aged 50-70, screened for breast cancer in last 36 months was 77% which was comparable to the CCG average of 80% and national average of 72.5%. Patients aged 60-69, screened for bowel cancer in last 30 months was 59% which was comparable to the CCG average of 61% and national average of, 57.5%.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision-making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 41 patient Care Quality Commission comment cards we received were positive about the service experienced. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and forty-nine surveys were sent out and 121 were returned. This represented about 1.3% of the practice population. The practice was above the national average for its satisfaction scores on consultations with GPs. For example:

- 92% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 93% and the national average of 89%.
- 91% of patients who responded said the GP gave them enough time compared with the clinical commissioning group (CCG) average of 91% and the national average of 86%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw compared with the clinical commissioning group (CCG) average of 97% and the national average of 95%.

- 94% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the clinical commissioning group (CCG) average of 91% and the national average of 86%.

The practice nurse satisfaction scores however, were slightly lower than the CCG and national averages, for example:

- 88% of patients who responded said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 94% and the national average of 91%.
- 91% of patients who responded said the nurse gave them enough time compared with the clinical commissioning group (CCG) average of 95% and the national average of 92%.
- 93% of patients who responded said they had confidence and trust in the last nurse they saw compared with the clinical commissioning group (CCG) average of 98% and the national average of 97%.
- 89% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the clinical commissioning group (CCG) average of 94% and the national average of 91%.
- 88% of patients who responded said they found the receptionists at the practice helpful compared with the clinical commissioning group (CCG) average of 90% and the national average of 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, communication aid materials such as a hearing loop were available.

Are services caring?

- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 79 patients as carers (1.8% of the practice list). A member of staff was the community and care co-ordinator at the practice to help ensure that the various services supporting carers were coordinated and effective.

- Staff told us that if families had experienced bereavement, the GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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 with local and national averages:

- 88% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 91% and the national average of 86%.
- 87% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the clinical commissioning group (CCG) average of 88% and the national average of 82%.
- 89% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 93% and the national average of 90%.
- 85% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the clinical commissioning group (CCG) average of 89% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice provided extended opening hours on a Saturday morning, online services such as repeat prescription requests, advanced booking of appointments and advice services for common ailments.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- A daily walk in phlebotomy clinic on weekday mornings for all patients.
- The practice care navigation team advanced access appointments system was in place enabling patient choice to see a GP or an advanced nurse practitioner on the same day as they call.
- The practice co-ordinated patients' long term condition reviews with invited voluntary sector service events at the practice. This enabled patients to access advice signposting and information services that were specific to meet their needs during the one practice visit. For example, information was provided from Shropshire's Rural Communities Charity (RCC) Wise and Well Team about a pilot project in the Oswestry area to match active buddy volunteers with older people who would benefit from activity. Shropshire RCC is an independent charity established over 50 years ago to benefit people in Shropshire, Telford & Wrekin. Volunteers help those with care and financial needs in the local community.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, Saturday morning appointments.
- Telephone and GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

Are services responsive to people's needs?

(for example, to feedback?)

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients experiencing poor mental health and those patients living with dementia.
- The practice was a pilot practice for the memory team to run open access clinics at the practice. The aim was to enable patients with possible dementia as well as those already diagnosed timely access to early treatment, advice and information.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher than local and national averages and for satisfaction with the practice's opening hours comparable to local and national averages. This was supported by observations on the day of inspection and the 41 completed comment cards. Two hundred and forty-nine surveys were sent out and 121 were returned. This represented about 1.3% of the practice population. Six of the 41 Care Quality Commission comment cards we received also provided comments for areas of improvement. These included; a blood test result delay error, a rushed appointment, prescription delay on occasions, the difficulty for some to attend the practice to gain an appointment at 8am and one person commented that it was up to three weeks for a routine appointment with their preferred GP.

- 95% of patients who responded said they could get through easily to the practice by phone compared with the clinical commissioning group (CCG) average of 84% and the national average of 71%.
- 75% of patients who responded were satisfied with the practice's opening hours compared with the CCG average of 78% and the national average of 76%.
- 85% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the clinical commissioning group (CCG) average of 88% and the national average of 84%.
- 89% of patients who responded said their last appointment was convenient compared with the clinical commissioning group (CCG) average of 86% and the national average of 81%.
- 87% of patients who responded described their experience of making an appointment as good compared with the clinical commissioning group (CCG) average of 81% and the national average of 73%.
- 63% of patients who responded said they don't normally have to wait too long to be seen compared with the clinical commissioning group (CCG) average of 61% and the national average of 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Eighteen complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.

The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, a patient was provided with a vaccination when in early pregnancy. Following investigation an apology was provided and specialist advice sought and given with resultant learning.

Are services responsive to people's needs?

(for example, to feedback?)

and actions taken to reduce future reoccurrence. For example, a failsafe system was introduced to ensure that

female patients are asked if they could be pregnant by reception staff when being asked to attend for an immunisation or vaccination appointment by the care navigation team and by the nursing staff.

Are services well-led?

Good 

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

Our findings

We rated the practice, and all the population groups, as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The strategic plans for the future included for example: changes to the partnership and recruitment, training foundation year doctors and medical students as well as registrars, nursing students, skill mix to potentially include allied health professionals, enhancing the care navigation system and GPs continuing where practicable to have external professional roles for example with Shropdoc, the out of hours provider.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. The practice described the patient experience beyond 2017. The practice had modified and reviewed their various systems in line with national and local developments and advances. This included more recently incorporating the 10 high impact areas to try to improve access and services for their patients, particularly in the fields of technology and communications. Examples included; the potential for a greater range of

professionals for patients to consult with, that once established this may provide the opportunity for longer GP appointments, remote monitoring, Skype consultations with care homes, better technology links and data sharing and other shared services such as home visits.

- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, in respect of a complaint, this was investigated and an apology provided, actions were taken which included a change of policy in patient urine sample specimen collections, contact with the community and care coordinator who provided additional documented information to support the patient and carer. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

Are services well-led?

Good 

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

- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of Medicines and Healthcare products Regulatory Agency (MHRA) alerts, incidents, and complaints.

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information, which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was a virtual active patient participation group.

Are services well-led?

Good 

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

- The service was transparent, collaborative and open with stakeholders about performance.
- The practice was looking to share a pharmacist between three practices in their locality and to continue to develop the care navigation system in place and enhance the clinical staff choices available for patient appointments.
- The practice was the sole dispensing practice in Oswestry and had recently adopted a dispensary system called Dispense IT as well as electronic prescribing to maintain and improve their dispensary activity.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. Examples included; implementation of a care navigator team who assist patients to the right clinician or service, a change from nurse triage to increased face-to-face nurse appointment times, the introduction of a daily morning dedicated GP phone call list, they also introduced a drop-in phlebotomy service as well as clinical staff taking blood samples for tests when required.
- The practice provided long-term condition clinics, which they tied in with third sector voluntary service presence at the practice to improve patient experience. They introduced a voluntary sector booking schedule in advance. We saw examples such as Citizens Advice and Carers Forums had been held in November 2017. The Alzheimer Society attended the same afternoon as the Memory Team Clinic. A Home Start Voluntary Agency attended on Wednesday afternoons to correspond with the practice mother and baby six week check and baby immunisation clinics,
- The practice was chosen as the pilot practice in Oswestry for the new local Social Prescribing Scheme, which was to be rolled out across Shropshire following the results of the pilot. Patients were referred to a link worker who provided access to a range of non-clinical support services delivered in the local community usually by the voluntary community and social enterprise sector (VTSE).
- The practice was a pilot practice for the memory team to run open access clinics at the practice. The aim was to enable patients with possible dementia as well those already diagnosed timely access to early treatment, advice and information.
- The practice chose to employ their own cleaning staff and in house caretaker who they found could be more responsive to any infection control issues.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. The practice focused on the staff and their working lives and introduced Agenda for Change employment terms and conditions.
- They linked with other local practices and partnership working looking to include research and training.
- As a team the practice also ran team outings and social events the latest being a team axe throwing competition.
- The practice has a refurbishment programme which more recently in response to patient feedback included refreshing the practice internal paintwork.