Marysville 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Marysville Medical Practice, on 24 June 2015. Overall the practice is rated as outstanding.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice valued the importance of quality, improvement and learning and were actively involved in the training and education of GPs, student nurses and counsellors.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Patients rated the practice highly in surveys and described the practice as caring and helpful.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was flexibility of access to appointments.

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- 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.

We saw areas of outstanding practice:

- The practice had developed and led on a project known as the Care Homes Advanced Scheme (CHAS) for care homes in the locality of Shrewsbury and Atcham, Shropshire. The aim of the project was to increase clinical input into care homes. The project was evaluated and recognised by the local CCG as an important initiative in preventing unplanned hospital admissions and providing more continuity to patients' in care homes. All GP practices had agreed to provide a service to a small number of care homes. Before this, patients living in care homes received care and treatment from as many as 14 practices.
- The practice had developed easy read leaflets which were given to patients with a learning disability to help them understand the care and treatment they received.
- The practice was committed to providing access to as many services as possible at the premises. Physiotherapy, counselling and chiropody services were provided for its registered population. Access to additional services included; British Pregnancy Advisory Service, regional hearing service, pain management service, vasectomy surgery and dermatology surgery were provided for patients registered at the practice and those from other practices. This allowed patients to access local care at the practice rather than a hospital setting.

There were two areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Review complaints over time to identify any themes or trends.
- Continue to review recruitment procedures to ensure that all staff who are involved in the direct care of patients such as providing treatment or chaperone duties are risk assessed to determine if a Disclosure and Barring Service (DBS) check is required.

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 to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored and addressed. Staff had attended training related to safety. This included areas such as safeguarding, infection control and prevention and chaperone training appropriate to their role. A comprehensive infection control audit had been completed and action was planned for any risks identified. The practice had not completed full recruitment procedures for all staff involved in the direct care of patients such as providing treatment or chaperone duties. Risk assessments had not been completed to determine if a Disclosure and Barring Service (DBS) check was required. Appropriate action was taken by the practice manager at the time of the inspection to address this. There were enough staff to keep patients safe.

Are services effective?

Outstanding 

The practice is rated as outstanding for providing effective services. Data showed patient outcomes were well above average for the locality. The practice had performed higher than many other practices in several areas and had achieved 95.9% of QOF points in 2014-15. 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 guidelines and other locally agreed guidelines. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

The practice had developed and led on a project known as the Care Homes Advanced Scheme (CHAS). This resulted in the practice introducing and being the leaders for the CHAS project pilot scheme for care homes in Shrewsbury and Atcham, Shropshire. The focus of the scheme was to increase and improve clinical input in care homes. The practice had an active involvement in the care homes they provided a service too. Practice staff had ensured patients had comprehensive assessments, care plans completed and received regular health reviews. The practice also provided regular education sessions for care home staff. One of the GPs at the practice was the lead for the scheme.

The practice was committed to providing access to as many services as possible at the premises to patients registered with them and those from other practices. This allowed patients to access local

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care at the practice rather than a hospital setting. The practice worked closely with other health professionals and community and voluntary services. These included community midwives, substance misuse workers, podiatrist, district nurse team, physiotherapist and the community pharmacist. Other additional services offered included; diabetic foot health screening, counselling, British Pregnancy Advisory Service, regional hearing service, pain management service, vasectomy surgery and dermatology surgery. The GPs had access to dedicated theatre facilities and the support of a theatre nurse who was employed by the practice.

The practice took a proactive role in the development of its own staff and other health professionals and students external to the practice. All practice staff had received training specific to their role in safeguarding, infection control and the role of a chaperone and further training had been undertaken and planned to meet the needs of patients registered with the practice. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. The patient survey information we reviewed showed patients responded extremely positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice highly in all areas. The practice had a patient-centred culture. We saw that staff were motivated and inspired to offer kind and compassionate care and staff worked to overcome obstacles to achieving this. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw that staff treated patients with kindness and respect, and maintained confidentiality. Information to help patients understand the services available was easy to understand. For example patients with a learning disability were given easy read leaflets to help them to understand the care and treatment offered.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services. It 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.

Following evaluation the CHAS project scheme had been recognised by the local CCG as an important initiative in preventing unplanned

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hospital admissions and providing more continuity to patients' in care homes. The project was implemented in phases and had resulted in GP practices agreeing to manage an agreed number of care homes. Before this, patients living in care homes were receiving care and treatment from all 14 practices in this area. This change has resulted in continuity of care for patients and staff working at the care homes now relate to a much smaller number of practices and was in the process of developing guidelines for staff on the management of falls and head injuries sustained in care homes.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The patient survey information for July 2015 showed that patients rated the practices highly in response to questions about access to appointments. For example, 92% were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%. One hundred per cent of respondents said they could get through easily to the practice by phone which was higher than both the local CCG and the national average.

A designated GP, practice counsellor and a community mental health nurse ensured that all patients experiencing poor mental health received appropriate treatment from appropriately qualified staff. Together they provided a weekly clinic and comprehensive package of care for those patients experiencing illnesses such as depression and anxiety. The involvement of the community mental health nurse provided an important link to the local mental health services. Patients with more than one long term condition had a full review at the same appointment. For example patients with diabetes were reviewed by the GP, nurse and podiatrist on the same day to avoid patients having to return on several occasions. Records showed for example that 191 of the 200 diabetic patients registered with the practice (95.5%) had received their annual review in this way. The remaining nine patients had their review completed at the local hospital. Learning from complaints was shared with staff.

The practice employed community care co-ordinators to support and facilitate care for vulnerable patients and to assist patients with varied health and social care needs. They supported patients to access services that could prevent further hospitalisation and also assisted vulnerable patients in their homes. This initiative had shown benefits for patients who were socially isolated and this was confirmed by patients.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. The strategy to deliver this vision had been produced

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with stakeholders and was regularly reviewed and discussed with staff. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. We saw that the practice worked extremely well as a team and worked to make and sustain improvements. All staff were involved in making improvements at the practice and had received training in the problem solving method process mapping. High standards were promoted and owned by all practice staff and the teams worked together across all roles.

Governance and performance management arrangements had been reviewed and took account of current models of best practice. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice carried out proactive succession planning. The practice GPs met daily to discuss any issues and share experiences. There was a comprehensive programme of education and training for all staff.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and the practice engaged well with the group. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. The practice used feedback from the PPG to improve the service provided to patients. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. To address the social isolation older people may experience the practice had employed community care coordinators who helped to fill these gaps in patients care and offered support to older frail patients in their homes. The practice provided a service to two care homes and offered personalised care to meet the needs of the older people in its population. The practice had a proactive role in a range of enhanced services, for example, in response to a CCG initiative "Increasing Clinical Input into Care Homes" the practice had developed and led on a project known as the Care Homes Advanced Scheme (CHAS). The practice also provided regular education sessions for care home staff and was developing guidelines to support care home staff in the management of falls and head injuries. The benefits of the CHAS project had identified a reduction of unnecessary referrals to hospital particularly in patients identified as being at risk of hospitalisation. Staff and patients interacted with a much smaller number of practices which resulted in continuity of care for patients living in care homes.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients over the age of 75 had a named GP. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. We saw that patients with more than one long term condition had a full review at the same appointment to avoid patients having to return on several occasions. For example patients with diabetes were reviewed by the GP, nurse and podiatrist on the same day. Records confirmed that all diabetic patients booked to have their review at the practice 191 had received their annual review in this way. Patients were pleased with this approach to their care. Meetings take place with other relevant health professionals to discuss patients with complex needs and to deliver a multidisciplinary package of care. The community care co-ordinator made telephone contact with any patients on the register within 48 hours of their discharge from hospital to ensure a comprehensive care package was in place and to assess whether any other services were needed.

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Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients with long term conditions had their health and medication regularly reviewed**.** The practice was involved in the prevention of unplanned admissions enhanced service. It maintained a register created from a risk tool that demonstrated at least 3% of the practice population had received a full care plan and were reviewed every three months by a health care assistant, practice nurses and GPs. This patient group were discussed every month with the multi-disciplinary team. Patients receiving end of life care were discussed every month at the multi-disciplinary meeting and care was delivered through the Gold Standards Framework. The Gold Standard Framework involved practice staff working together as a team and with other professionals in hospitals, hospices and specialist teams to help to provide the highest standard of care possible for patients with advanced disease and their families.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people. There were systems in place 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 A&E attendances. The practice had a higher rate of immunisations than the national and local average. The practice consistently achieved a higher than national and local rate for cervical screening. The practice nurses had developed a personalised letter to send to women who did not attend for their cervical screening appointment.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, who carried out a weekly clinic at the practice. Contraceptive services and advice were available at the practice.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding 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. Appointments were available outside of working hours. The practice offered one early morning clinic each week and remained

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open at lunchtime to allow patients, particularly those who were working to access services at the surgery. Booked telephone consultations were offered four evenings each week. This flexibility was extremely popular with patients who would be at work during the practice normal opening hours. Telephone consultations were introduced in response to a patient survey. Patients commented that they would prefer this to appointments in the early morning or at weekends. The practice was proactive in offering online services and patients had access to online appointments and prescriptions. NHS health checks were offered as well as a full range of health promotion and screening that reflects the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice had systems in place to ensure that they could identify patients living in vulnerable circumstances including homeless people and those with a learning disability. Homeless patients could be registered with the practice and access any of the services as needed. The practice provided a counselling service which patients could access following referral by their GP. Fifty five percent of the 71 patients referred to the counsellor had accepted counselling over the past year (2014 – 2015). The practice employed community care co-ordinators to assist patients with varied health and social care needs. The coordinators signposted patients to appropriate services and support provided by the voluntary sector and assisted them in their homes. This initiative had shown benefits for patients who were socially isolated and this was confirmed by patients. The lead community care co-ordinator contacted all patients on the unplanned admissions register who had been admitted to hospital within 48 hours of discharge. These patients were supported to access any other services that could prevent further hospitalisation.

The practice offered substance (alcohol and drugs) misuse clinics to assess and manage the care of patients who presented with substance misuse health issues. One of the GPs provided a shared care service to patients with substance misuse with the support of community support teams. Information provided demonstrated the effectiveness of this service over the past twelve months. Records showed that of the 19 patients on the practice register there had been a clinic attendance rate of 94 –100 percent over the past year (2014 – 2015). Systems were in place to follow up patients who did not attend for their appointment. The practice maintained a register of patients with a learning disability. Patients were offered annual health reviews and given longer appointments. All patient's had

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received a follow-up. There was a designated practice nurse lead for learning disabilities. Easy read leaflets were given to patients with a learning disability to help them to understand the care and treatment offered.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. A designated GP, the practice counsellor and a community mental health nurse carried out a weekly clinic for patients experiencing poor mental health. The team ensured patients received treatment from appropriately qualified staff. Together they provided a comprehensive package of care for those patients experiencing illnesses such as depression and anxiety. The involvement of the community mental health nurse also provided an important link to the local mental health services. All people experiencing poor mental health had received an annual physical health check. Patients were also encouraged to access local support groups as part of their care package. Practice staff had received training on how to care for people who experienced poor mental health.

The practice had a dementia diagnosis rate of 69.4% which reflected the special interest of one of the GPs in elderly care and the promotion of continuing care in care homes. This rate was significantly higher than other practices in the locality (4th highest out of 44 practices across Shropshire). Shropshire CCG had estimated a diagnosis rate of 49.1% across Shropshire. This achievement had been recognised by the local CCG commissioning lead for dementia. The commissioning lead had approached the practice to discuss how they had achieved this diagnosis rate so that the practice could share their systems with other practices. The practice carried out advance care planning for patients with dementia. The community care coordinator signposted patients and their carers to various support groups available locally.

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What people who use the service say

We spoke with eleven patients during our inspection, three of whom were members of the practice patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. We spoke with and received comments from patients who had been with the practice for a number of years and patients who had recently joined the practice. Patients we spoke with during the inspection were extremely positive about the service they received and could not praise the practice and its staff enough. They told us that they were treated with respect, were listened to, had plenty of time to talk to GPs and they received a first class service. Patient's described the staff and GPs as very polite, accommodating and approachable.

We reviewed 38 patient comment cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that all the comments made were positive about the service they experienced. One comment although positive also felt that on occasion they had been rushed; however they highly praised the practice staff. The common themes in comment cards were excellent, praise for all staff, nothing was too much trouble and always time to listen and explain treatment.

The July to September 2014 and January to March 2015 national GP patient survey showed that these experiences were also expressed in the survey and the practice performed extremely well in all areas when compared to other practices locally. These included:

- 84% of respondents who had a preferred GP said that they usually got to see or speak to that GP as compared with the local Clinical Commissioning Group (CCG) average of 63%.
- 81% of respondents said that they usually waited 15 minutes or less after their appointment time to be seen as compared with the local CCG average of 65%.
- 92% of respondents said that they were satisfied with the surgery's opening hours as compared with the local CCG average of 76%.
- 99% of respondents said that they had confidence and trust in the last nurse they saw or spoke to as compared with the local CCG average of 98%.
- 96% of respondents said that the last nurse they saw or spoke to was good at treating them with care and concern as compared with the local CCG average of 93%.
- 100% of respondents had confidence and trust in the last GP they saw or spoke to as compared with the local CCG average of 97%.

Areas for improvement

Action the service SHOULD take to improve

- Review complaints over time to identify any themes or trends.
- Continue to review recruitment procedures to ensure that all staff who are involved in the direct care of patients such as providing treatment or chaperone duties are risk assessed to determine if a Disclosure and Barring Service (DBS) check is required.

Outstanding practice

- The practice had developed and led on a project known as the Care Homes Advanced Scheme (CHAS) for care homes in the locality of Shrewsbury and Atcham, Shropshire. The aim of the project was to increase clinical input into care homes. The project was evaluated and recognised by the local CCG as an important initiative in preventing unplanned hospital admissions and providing more continuity to patients'

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in care homes. All GP practices had agreed to provide a service to a small number of care homes. Before this, patients living in care homes received care and treatment from as many as 14 practices.

- The practice had developed easy read leaflets which were given to patients with a learning disability to help them understand the care and treatment they received.
- The practice was committed to providing access to as many services as possible at the premises.

Physiotherapy, counselling and chiropody services were provided for its registered population. Access to additional services included; British Pregnancy Advisory Service, regional hearing service, pain management service, vasectomy surgery and dermatology surgery were provided for patients registered at the practice and those from other practices. This allowed patients to access local care at the practice rather than a hospital setting.

Marysville Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Marysville Medical Practice

Marysville Medical Practice partnership based in the county town of Shrewsbury, Shropshire. The practice was purpose built in 2005 and provides access to consulting rooms at ground and first floor level. Any services provided on the first floor are accessible by passenger lift. The building is fitted with automatic doors to assist wheelchair users. The surgery is in a residential area and has good parking facilities. The practice provides services to patients of all ages based on a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community.

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

A team of three GP partners, a part time salaried GP, two practice nurses, one theatre nurse, one health care assistant and a care co-ordinator provide care and treatment for approximately 5,074 patients. There is two female and one male GP. A further male GP undertakes dermatology surgery only. The clinical team are supported by ten administrative staff. The team is led by a practice manager and includes a deputy manager and a trainee undertaking an administration apprenticeship. The practice is a training practice for GP trainees and medical students to gain experience and higher qualifications in general practice and family medicine. The practice is also working with a local university and will be taking student nurses on placement within the practice as part of their training from September 2015.

The core opening hours for the practice were open from 8am to 6.30pm on Monday to Friday. Appointments with a GP were held from 9am to 10.30pm and 8.40am to 12.30am with a practice nurse. Home visits and urgent visits were carried out between 10.30am and 2pm. Further routine and urgent appointments were available between 3pm and 5.30pm daily. The practice offered early morning appointments on Tuesdays from 7.30am to 8am. The practice also remained open at lunchtime to allow patients, particularly those who worked flexible access services to the practice. Extended hours were available to patients from 6.30pm to 7.20pm. Booked telephone consultations were offered three evenings each week. The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to the out-of-hours service, Shropdoc when the practice is closed.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as part of our

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regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- 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 visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 24 June 2015. During our visit we spoke with a range of staff including practice nurses, receptionists, GPs, practice manager and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a GP identified that part of the equipment used to test glucose (sugar) levels in patients was out of date. This was added to the list of items to be checked for example equipment and medicines when GP bags are checked monthly.

We reviewed safety records, incident reports where these had been monitored informally for the past ten years. We saw minutes of meetings where these had been discussed formally at significant event meetings for the last six months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. However the practice had not reviewed all of the past events to show any action taken had been appropriate and prevented reoccurrence also to identify any themes or trends.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 54 significant events that had occurred during the last two plus years and saw this system was followed appropriately. One of the GPs had attended a local significant events course which looked at how significant events could be managed at the practice. As a result a no blame culture was adopted to encourage staff to report all incidents both negative and positive. The practice used a method called process mapping to review significant events. This meant all staff contributed to identifying where the problems were arising and how they could be solved. The practice also introduced dedicated monthly meetings to discuss significant events in December 2014. The meetings were attended by the GP partners, lead practice nurse, practice manager and the deputy practice manager. The outcome of the meetings, action to be taken and lessons learned was shared with staff groups at their individual team meetings.

All staff reported and entered incidents onto a template on the practice intranet these were then assessed by the practice manager and transferred onto the local incident reporting system. There was evidence the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that learning had been shared. For example a patient who presented at the practice with breathing problems but did not have an appointment was asked to wait to see a GP. The reception staff had not realised the urgent need for the patient to be seen and the GPs were not made aware of the patients' presence at the practice. This was addressed as a significant event which involved discussion with the receptionists and a review of policies and procedures at the practice. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. The practice nurse told us about a recent alert related to a specific batch of vaccines that had to be withdrawn. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

There was a lead GP for safeguarding at the practice. We looked at training records which showed all staff had received relevant role specific training on safeguarding to an appropriate level. For example, the GPs had received training to level three as suggested in guidance by the Royal College of Paediatrics and Child Health on safeguarding children and young people (March 2014).

Policies for safeguarding children and vulnerable adults were available on the practice's computer system for staff to refer to for support and guidance. These contained information about identifying, reporting and dealing with suspected abuse that was reported or witnessed. Staff we

spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. Staff were also aware of their responsibilities and knew how to share information and how to contact the relevant agencies in and out of normal hours. Practice staff had been proactive in reporting safeguarding concerns and told us about two safeguarding referrals that the practice had made. We saw that appropriate action had been taken and as a result of the referrals that additional care or support had been put place to support these patients.

The practice had a system in place to monitor children who could be at risk. Alerts were place on patient clinical records to indicate they had not attended for childhood immunisations, or have had high levels of attendances at the accident and emergency department (A&E).

There was a chaperone policy in place at the practice for staff to refer to for support. Signs informing patients of their right to have a chaperone present during an intimate examination were clearly displayed throughout the practice and information included in the practice information booklet. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. We spoke with one of the practice nurses who clearly described to us their role and responsibilities in protecting patients from the risk of abuse and knew what action to take if they had any concerns.

We found that two members of staff involved in providing treatment and care to patients had not had Disclosure Barring Services (DBS) criminal record checks carried out or had risk assessments completed to ensure they were suitable to undertake their roles. DBS checks are carried out to 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. At the time of our inspection the practice manager completed risk assessments, started the DBS process, and put plans in place for both staff to be supervised whilst they awaited the outcome of the DBS checks.

Medicines management

We checked the medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. A log of the fridge temperature ranges had been recorded twice daily which demonstrated that vaccines stored in the fridges were safe to use because they had been stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range. Practice staff we spoke with understood why and how to follow the procedures identified in the policy.

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

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

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were appropriate and necessary. There were systems in place to check that GP prescription pads used could be tracked through the practice. Systems were also in place for nursing staff to check or seek confirmation that the medicines and equipment in GP bags (used when visiting patients in the community) were up to date and fit for use.

Cleanliness and infection control

One of the practice nurses was the lead for infection control and had undertaken further training to enable them to provide advice on infection control. All staff had received training about infection control specific to their role. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. The infection

control lead and the deputy practice manager had completed a comprehensive infection prevention and control audit in June 2015. We saw that an action plan had been developed to address areas of risk identified. For example this included the plan for replacing carpets in clinical areas and treatment rooms over time.

The practice was visibly clean and tidy and staff followed appropriate infection control procedures to maintain this standard. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Reasonable steps to protect staff and patients from the risks of health care associated infections had been taken. Staff had received relevant immunisations and support to manage the risks of health care associated infections. A legionella risk assessment had been completed in February 2015 to help protect patients and staff from harm. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that there were procedures in place to prevent the growth of legionella. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had the equipment needed to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was 29 June 2014. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. All medical devices were calibrated in October 2014 to ensure they were safe to use.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Three of the five staff records we looked at contained evidence that 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 (These 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). We found that two staff involved in the direct care of patients had not had DBS checks completed. The practice manager implemented appropriate action at the time of the inspection to address this.

There were sufficient numbers of staff with appropriate skills to keep people safe. Staff rota systems were in place and assessments of the needs of additional staff had been carried out. These took into account changes in demand, annual leave, patient requests and sickness. Staff told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Risks from equipment, suitability of staff, buildings and environmental factors had been mitigated by commissioning outside agencies to deal with some of the issues that may impact on safety. For example, all fire equipment, servicing, testing and fire drills were managed by a company with a background in that area.

The staff we spoke with were able to describe the actions they would take if they were faced with an emergency situation, for example a patient whose health deteriorated suddenly. Practice staff gave us examples of situations they had appropriately dealt with.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all clinical staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked monthly to ensure it was fit for purpose.

Good

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A comprehensive business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of premises, adverse weather, unplanned sickness and the loss of domestic services. The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that a practice fire drill had been carried out last year. Regular checks of the building and premises was undertaken to ensure that any untoward risks could be identified and acted on immediately.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in clinical and consulting rooms.

We discussed with the GPs, nurses and practice manager how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed these were discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. The practice nurse we spoke with showed us how they accessed the NICE guidance and used the care of a diabetic patient as an example.

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

For example, the practice used tele-dermatology to send pictures of patients skin conditions to hospital based specialists to speed up and improve diagnosis and treatment.

The GPs told us they lead in specialist clinical areas such as diabetes, family planning, substance misuse and mental health. The practice nurses were qualified to support this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of asthma and heart conditions. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised systems to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their health and care needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicine management. The information staff collected was then collated by designated staff and GPs to support the practice to carry out clinical audits.

The practice showed us two completed clinical audits that had been undertaken in the last 12 months. One of the audits looked at preventing hospital admissions related to medicines (HARMS). The aim of the audit was to evaluate whether the practice was monitoring patients prescribed high risk medicines. The audit was completed with the support of the CCG pharmacist. The first cycle identified 116 patients were taking high risk medicines of these seven (6%) patients did not have their monitoring completely up to date. The second cycle identified 140 patients within the practice were taking high risk medicines of these eight (5.7%) patients had not had monitoring carried out. On both occasions patients who were missing appropriate blood tests were contacted and had appropriate monitoring and a flow chart developed to ensure safe prescribing. The practice had made comparison between the two audits to identify any trends or shortfalls. Robust systems were put in place for reporting on medicine

monitoring, near patient testing and follow up diary dates were documented to ensure no patients are missed. There was a written protocol in place for allocated staff to follow related to medicines monitoring. The protocol involved running a monthly report to ensure patient list is up to date, tests required and follow up appointments allocated. A specific appointment card had also been developed. We saw the documents to confirm this. The local CCG had commended the process used the practice to monitor patients taking high risk medicines. The process had been shared as an example of best practice and was used by other GP practices as a guideline for monitoring.

The GPs told us clinical audits were linked to best practice guidance, medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, in 2008, 2013 and 2015 the practice reviewed their hepatitis A and B immunisation rates for patients who misused identified medicines. The practice acknowledged that although there had been improvements the figures were low and when compared to the previous audit cycles there was minimal improvement. It was also apparent that patients had not completed the courses of Hepatitis A and Hepatitis B. The practice had an action plan in place to address this, which included allowing this group of patients to have a walk in arrangement rather than fixed appointments.

The practice routinely collected information about patients' care and outcomes. This included data for the Quality and Outcome Framework (QOF), clinical audits, and compared its performance against other practices in the local Clinical Commissioning Group (CCG). The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The practice had performed higher than many other practices in several areas and had achieved 95.9% of QOF points in 2014-15 with a clinical exception rate of approximately 7.1%. For example, all patients with chronic obstructive pulmonary disease and all patients with asthma had received an annual review. (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema). The practice had also performed strongly in other areas this included, all patients who experienced poor mental health had a plan of care implemented. A further example showed that all patients with a learning disability had an agreed care plan in place. These results were all above the national target.

The practice had a dementia diagnosis rate of 69.4% which was significantly higher than other practices in the locality (4th highest out of 44 practices across Shropshire). Shropshire CCG had estimated a diagnosis rate of 49.1% across Shropshire. The practice had been approached by the commissioning lead for the CCG to discuss the systems they used to achieve this diagnosis rate with the view that these could be shared with other practices. All patients with dementia had had a face to face review in the last 12 months.

In response to a CCG initiative "Increasing Clinical Input into Care Homes" the practice had developed and led on a project known as the Care Homes Advanced Scheme (CHAS). This resulted in the practice introducing and being the leaders for the CHAS project pilot scheme for care homes in the locality of Shrewsbury and Atcham, Shropshire. The pilot scheme was based on the input GPs at Marysville Medical Practice had put into the care homes where they provided a service. Their active involvement in care homes had ensured patients had comprehensive assessments, care plans completed and received regular health reviews. The practice also provided regular education sessions for care home staff. One of the GPs at the practice was the lead for the scheme and was in the process of developing guidelines for staff on the management of falls and head injuries sustained in care homes.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP. All repeat medicine requests that are past their review date were passed to a GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We discussed one area related to medicine prescribing where the practice had performed below the national average (50.19% as compared to the national average of 71.25%) for the review of the number of Ibuprofen and Naproxen (medicines used to treat inflammation or pain). Guidance available recommends

that a review of the appropriateness of NSAID (anti-inflammatory) prescribing widely should be carried out on a routine basis. The GPs told us that they planned to review this.

Effective staffing

Staff had received training appropriate to their roles, and had protected learning time for ongoing training. Continuing professional development for nurses was monitored through appraisals, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice. There was a good skill mix among the GPs with two having additional diplomas in the treatment of patients presenting with substance misuse, treatment of diabetes and family planning. A further GP had plans in place to attend an end of life training day to update themselves on the new end of life care model. This information would then be shared with staff at the practice and a review of practice undertaken and updated as appropriate.

All the GPs we spoke with were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The practice was a training practice for GP trainees (doctors training to be qualified as GPs). Although there were no GP trainees undertaking training at the time of inspection the GP partners told us that the registrars had access to a senior GP throughout the day for support. One of the GPs had a special interest in GP training.

The practice nurses were expected to perform defined duties and had extended roles. The nurses were able to demonstrate that they were trained to fulfil these duties. For example, the nurse had completed appropriate training to undertake the administration of childhood immunisations, vaccinations and cervical screening. GP support was available to the practice nurses at all times. The practice manager told us about their plans to offer student nurses placements at the practice to student nurses from Stafford University. This would introduce student nurses to the work of a practice nurse and could have an impact on the long-term recruitment of practice nurses. The first student nurses were due to commence at the practice in September 2015. The practice would be the first in Shropshire to offer these placements.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. We spoke with the manager of a local care home. They told us the practice worked with them to meet the needs of patients and that there was effective communication between them and the practice to support the sharing of information. The practice held regular meetings with staff at the care home and provided training related to the care of the elderly. Regular multidisciplinary meetings were held to discuss the needs and treatment of patients with long-term conditions, palliative care needs, vulnerable and older frail patients who were at high risk of unplanned hospital admissions. Other professionals attending these meetings included district and palliative care nurses.

The practice was committed to providing as many services as possible at the premises to patients registered with them and those from other practices. This allowed patients to access local care at the practice rather than a hospital setting. These included community midwives, substance misuse workers, district nurse team, physiotherapist and the community pharmacist. The practice worked with the community pharmacist when carrying out reviews of the treatment of patients with asthma. Other additional services offered included; British Pregnancy Advisory Service, regional hearing service, pain management service, vasectomy surgery and dermatology surgery. The GPs had access to dedicated theatre facilities and the support of a theatre nurse who was employed by the practice. All patients were made welcome and had access to the services of the practice reception team. Patients not registered with Marysville Medical Practice commented extremely positively on the facilities available at the practice. All patients were grateful that these services were easily accessible to them and commented on the good parking facilities available.

The practice counsellor and a community mental health nurse ensured that all patients experiencing poor mental health received appropriate treatment from appropriately qualified staff. The community mental health nurse was from the Community Mental Health Team and attended the

practice each week to undertake a clinic for patients experiencing poor mental health. The practice counsellor received all referrals from the GPs at the practice. Together they provided a comprehensive package of care for those patients experiencing illnesses such as depression and anxiety. The practice provided a counselling service which patients could access following referral by their GP. Fifty five percent of the 71 patients referred to the counsellor had accepted counselling over the past year (2014 – 2015). The involvement of the community mental health nurse also provided an important link to local mental health services.

The practice employed care co-ordinators to support and improve outcomes for vulnerable patients. The care co-ordinator facilitated local support for frail older people and telephoned patients following any hospital admissions to check on their health and wellbeing.

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

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence that the practice had used significant events to learn and improve information sharing between the practice and other providers.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This system enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. Some patients were asked to complete a pre-assessment questionnaire followed by pre-operation counselling to enable them to make an informed consent.

There was a practice policy for documenting consent for specific interventions. There was reference in the practice's consent policy to the MCA 2005 for staff to refer to for support and guidance. We saw that there was a form to obtain informed written consent for minor surgery and the withdrawal of consent which were scanned into patients' records.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The healthcare assistant actively engaged patients in lifestyle programmes. The practice had performed better than other practices in the local CCG area for monitoring and supporting patients who smoked. Information showed that 86.4% of patients had their smoking status recorded and 80.6% of these patients had accepted support to help them stop smoking. The practice sign posted patients to weight loss clinics provided in the community.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2013 -2104 showed that the practice had a higher rate of childhood immunisations than the national and local average for the local CCG except for the 12 month

Outstanding ☆

Are services effective?

(for example, treatment is effective)

meningitis C immunisation. In response to this the practice had looked at ways of improving the attendance rate of children. We saw that the changes made by the practice had been effective and failure to attend rates had decreased from 20.4% to 7.3%. Practice nurses used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition. The practice website contained health advice and information on long term conditions, with links to support organisations.

There were systems in place to support the early identification of cancers. The practice carried out cervical screening for women between the ages of 25 and 64 years.

We saw that the practice's performance for cervical smear uptake was 80.2% which was above the national average. The practice consistently achieved a higher than national and local rate for cervical screening. Women who failed to attend their cervical screening appointment were sent a personalised letter offering an alternative appointment. Public Health England National data showed that the practice was also proactive in screening for cancers such as bowel and breast cancer.

We saw that up to date health promotion information was displayed, available and easily accessible to patients in the waiting area of the practice.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in July 2015. The survey included responses collected during July to September 2014 and January to March 2015. There were 261 survey forms sent out of which 114 (43.7%) responses were returned.

The overall results of the GP Patient Survey placed the practice well above the national and locality averages in all areas surveyed. Results showed that 100% of patients said the overall experience of this practice is very good and 97% would recommend the practice to someone new to the area. The outcome of surveys undertaken by the PPG also reflected the caring nature of the practice. This included all staff, GPs, nurses and reception staff. This is further supported by the positive comments made on NHS Choices and the feedback received by the Friends and Family Test.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated higher for patients who rated the practice as good or very good. The practice was also above average when compared to the local and national satisfaction scores on consultations with GPs and nurses and the support received from receptionists. For example:

- 98% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 93% and national average of 89%.
- 98% said the GP gave them enough time compared to the CCG average of 92% and national average of 87%.
- 97% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 94% and national average of 91%.
- 98% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 94% and national average of 92%
- 97% said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 38 completed cards. The cards contained exceptionally positive comments about the practice and staff. Patient comments said that the service was excellent, they were treated with respect and dignity, GPs and staff were first class and they were dealt with professionally and efficiently at all times. We also spoke with eleven patients on the day of our inspection which included three members of the patient participation group. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place and a further quiet area was available if patients wanted to have a discussion in private.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. There was a clearly visible notice in the patient reception area and on the practice web site stating the practice's zero tolerance for abusive behaviour. Receptionists could refer to this to help them to manage potentially difficult situations. There had been pro-active planning for the care of a patient who had caused difficulties in their previous practice. The practice staff had developed an agreement with the patient on attendance at the practice and how they could best work together to best meet the patient's expectations. Monitoring of the patient demonstrated that a stable interaction with the practice was established.

Care planning and involvement in decisions about care and treatment

Outstanding ☆

Are services caring?

The patient survey information we reviewed showed patients responded extremely positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice highly in these areas. For example:

- 99% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 86%.
- 97% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 81%.
- 97% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.
- 93% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 90% and national average of 85%.
- 100% said that they had confidence and trust in the last GP they saw or spoke to compared to the CCG average of 97% and national average of 95%.
- 99% said they had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 98% and national average of 97%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they were involved in decision making about the care and treatment they received. They also told us they were listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. This enabled them to be involved in decisions about their care. We saw notices in the reception areas informing patents this service was available. Patients were also encouraged to use their own translator if they wanted to.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 97% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.
- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff were professional, efficient and caring. Notices in the patient waiting room and patient website informed patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided cared for. To do this, carers were offered health checks and support from a care co-ordinator. Links had been developed with voluntary organisations such as Alzheimer's Society (Supports people with dementia and their families) and Compassionate Communities (Offers support to people at end stage of life and their families).

The practice had a system in place to support patients known to them who had suffered a recent bereavement. We saw that practical advice about what to do in times of bereavement was available for patients on the practice's website. A GP telephoned them to check on their health and welfare and a home visit was made with the patient's consent. Patients were also supported by the community care co-ordinators.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice provided a service for 19 patients who experienced problems with alcohol and drug misuse. The practice offered substance (alcohol and drugs) misuse clinics to assess and manage the care of patients who presented with substance misuse health issues. One of the GPs who had a diploma in the care of patients who presented with substance misuse worked closely with the local substance misuse team to support these patients. Information provided demonstrated the effectiveness of this service over the past twelve months. Records showed that of the 19 patients on the practice register there was a 94 – 100% attendance rate at these clinics. Systems were in place to follow up patients who did not attend for their appointment.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. One of the GPs was due to attend a training day with a local hospice on a new end of life care model that was due to be implemented.

The practice employed care co-ordinators to support and facilitate care for vulnerable patients. The care co-ordinator facilitated local support for frail older people and telephoned patients following any hospital admissions to check on their health and wellbeing.

The practice employed a counsellor who supported patients who presented with emotional and stress related conditions. Seventy one patients had been referred to the counsellor and 55% of the 71 patients had accepted counselling over the past year (2014 – 2015). Patients also had access to physiotherapy services two mornings a week following referral by a GP.

We saw that all patients with more than one long term condition had a full review at the same appointment to avoid patients having to return on several occasions. For example, we were shown anonymised records for patients with a recorded diagnosis of diabetes that confirmed they had been reviewed by a GP, nurse and podiatrist on the same day. Two patients we spoke with and comments received in three comment cards confirmed that these reviews had taken place. One of the patients told us that having one appointment saved them making several journeys.

The practice main population age groups were 15-44 (36%) and 45-64 (29%). It provided services that would meet the health care needs of these age groups. For example, sexual health care chlamydia screening, free condoms, family planning, cytology screening, extended hours one morning a week, pre bookable telephone consultations, wellbeing screening, and on line services for appointments and prescriptions. The practice consistently achieved a higher than national and local rate for cervical screening. The practice nurses had developed a personalised letter which was sent to women who did not attend their cervical screening appointment. A copy of the letter was available. Information in meetings documentation showed that the practice took a lead role in local initiatives.

The NHS England Team and local Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population.

Following evaluation the CHAS (A local project to increase clinical input in care homes) scheme had been recognised by the local CCG as an important initiative to increase in preventing unplanned hospital admissions and providing more continuity to patients' in care homes. The Practice Manager played a leading role in reaching an agreement with local practices to provide the scheme to identified care homes. The practice was committed to the project and worked hard to demonstrate the benefits and encourage other GP practices in Shrewsbury and Atcham to embrace the scheme. This had resulted in GP practices agreeing to manage an agreed number of care homes. Before this, patients living in care homes were receiving care and treatment from all 14 practices. This change has resulted in continuity of care for patients and staff working at the care homes now relate to a much smaller number of practices.

The practice had implemented suggestions for improvements and made changes to the way it delivered

Are services responsive to people's needs?

(for example, to feedback?)

services in response to feedback from patients and the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with three members of the PPG who told us about the patient survey carried out in 2014 they received 130 replies. Comments were made by 32 patients requesting extended hours and weekend opening. The patient group was informed weekend opening was available in the past but very few patients used the service. Extended hours arrangements were changed to offer early morning appointments and telephone consultations after 6pm on 4 evenings per week. Further action taken by the PPG was to develop patient information leaflets. These included information on who patients could expect to see at the practice and information on follow up appointments. Health talks were arranged for the group for example one of the topics covered was mental health.

Tackling inequity and promoting equality

The practice provided equality and diversity training for all staff and we saw evidence of this. Staff we spoke with confirmed they had completed equality and diversity training.

The practice recognised the needs of different groups in the planning of its services. The practice was a two storey building, providing clinical treatment for patients on both floors. The first floor was accessible by a lift or stairs. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included designated parking spaces; level access to the automatic front doors of the practice and toilets for patients with a physical disability. Patients made positive comments on the good parking facilities available. The practice had a small population of patients whose first language was not English; staff had access to translation and interpretation services to ensure patients were involved in decisions about their care.

The practice provided care and support to patients who lived in two local care homes for older people. Staff at one of the care homes told us they worked in partnership with the practice to meet the needs of the patients and spoke highly of the GPs. They told us the practice was very responsive and the GPs always visited on request. Patients over 75 years of age and those patients with an end of life care pathway in place had a named GP to ensure continuity of care. There were no homeless patients registered with the practice, however if someone came to the practice asking to be seen staff told us they would register the patient so the patient could access the service without difficulty.

Access to the service

The core opening hours for the practice were open from 8am to 6.30pm on Monday to Friday. Appointments with a GP were held from 9am to 10.30pm and 8.40am to 12.30am with a practice nurse. Home visits and urgent visits were carried out between 10.30am and 2pm. Further routine and urgent appointments were available between 3pm and 5.30pm daily. The practice offered early morning appointments on Tuesdays from 7.30am to 8am. The practice also remained open at lunchtime to allow patients, particularly those who worked flexible access services to the practice. Extended hours were available to patients from 6.30pm to 7.20pm. Booked telephone consultations were offered three evenings each week. These were extremely popular with patients who would be at work when the practice was open. The telephone consultations were introduced in response to a patient survey undertaken by the PPG where patients stated they would prefer these to appointments in the early morning or at weekends. The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to the out-of-hours service, Shropdoc when the practice is closed. The GP Survey showed that 97% of patients were satisfied with the appointment system which was significantly higher than the national (82%) and local average (73%).

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The patient survey information we reviewed for July 2015 showed that their experience of the out of hours service was positive.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available for older patients, children, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions.

The patient survey information we reviewed for July 2015 showed that patients rated the practices highly in response to questions about access to appointments. For example:

- 92% were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 81% said they usually waited 15 minutes or less after their appointment time compared to the CCG and national average of 65%.
- 96% described their experience of making an appointment as good compared to the CCG average of 82% and national average of 73%.
- 100% said they could get through easily to the surgery by telephone compared to the CCG average of 85% and national average of 73%.

The patient views in the comments cards we received showed that patients were happy with the appointment system and told us that they could always get an appointment. This was confirmed by the patients we spoke with.

Patients were extremely positive about the ease of access to additional services provided at Marysville Medical Practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated person who handled all complaints in the practice. Information on how to complain was in the patient information leaflet and on the practice's website. We looked at a summary of complaints made during the last 12 months and saw they had been responded to in line with the practice's complaints policy with a full explanation and apology. All complaints were raised as significant events, and investigated. The practice discussed complaints with staff at the appropriate staff meeting, and was able to demonstrate changes made in response to feedback, such as changes in the way the repeat prescriptions were set up. However, they had not reviewed complaints over time to identify any common themes or trends.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were displayed on the practice website. The practice vision and values included to provide high quality, accessible general medical services to our patients and to provide services in a safe, professional and comfortable environment. Comments we received from patients reflected the practices vision in that patients felt they received high quality safe care and services.

We spoke with nine members of staff and found that all of the staff knew and understood the vision and values for the development of the practice. Staff knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of meetings held at the practice and saw that staff had discussed and agreed the vision and values for the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in folders, on the desktop on any computer within the practice. We looked at five of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All five policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for immunisations and the GP partner was the lead for safeguarding. The nine members of staff we spoke with were all clear about their own roles and responsibilities. All staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. GPs at the practice were proactive in getting involved with local CCG initiatives and were keen to lead on projects to improve care and treatment for patients registered with the practice and those in the wider community.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed that they had achieved 95.9% of available QOF points compared with a national value of 94%. We saw that QOF data was regularly discussed at monthly meetings. We saw that actions had been taken to maintain or improve patient outcomes.

The practice had a programme of clinical audits to monitor quality and systems to identify where action should be taken. Audits previously carried out were related to the validation of QOF information, clinical audit practice and medicine reviews. Completed audits showed that improvements were made to services and care and treatment provided by the practice.

Evidence from other data sources, including incidents and complaints were used to identify areas where improvements could be made. The practice had a system in place for handling complaints and concerns. There was a designated person who handled all complaints in the practice. Information on how to complain was in the patient information leaflet and on the practice's website. All complaints were raised as significant events, and investigated using the process mapping system. However complaints had not been reviewed over time to identify any common themes or trends. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, for example loss of the computer system. We saw that the risk log was regularly discussed at meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. In the event of the loss of the main computer operating system, practice staff had identified alternative computers and installed a back-up computer system to allow staff to access patient information and guidelines.

Are services well-led?

Good

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

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example grievance, health and safety, induction policy, equality which were in place to support staff. We were shown the electronic and hard copy of the staff handbook which was available to all staff and included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

All the members of the team we spoke with had confidence in the GP partners and management team as trustworthy leaders. The partners and managers in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen. Staff told us that they were all involved in discussions about how to run the practice and develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. The practice used a system called process flow mapping which enabled all staff to be involved in the change process. All staff had been trained to use the process. Staff described working at the practice as team spirited and caring. Staff said they felt respected, valued and supported.

The partners and management team placed great emphasis on communication within the practice. We saw evidence of regular practice meetings with comprehensive agendas and full minutes. We saw from minutes that team meetings were held regularly, at least monthly. We also noted that all staff had the opportunity to attend external events and away days as a team. Some of the events that took place also included the families of staff working at the practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example induction policy and recruitment which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The Chair of the PPG told us that the group had strong support from the practice with a keen, interested involvement. In addition to monthly meetings, the Chair of the group visited the practice one morning a week for an informal meeting with the patient services manager. The practice had also developed a patient reference group as a sounding board for new ideas.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said that they were actively encouraged to suggest improvements at the practice. They said they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

The practice had gathered feedback from patients through patient surveys, family and friends test, compliments and complaints received. We looked at the results of the patient participation group (PPG) patient survey for 2014 and saw appropriate action was taken to address comments and suggestions made by patients. For example changes were made to the appointment systems based on patients comments received. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had an active PPG which consisted of eight members. The PPG included male and female members. The group was also supported by a virtual group of approximately 90 patients. The PPG met monthly with the practice manager, deputy practice manager. The community care coordinator or GP attended most meetings. The group ensured that the virtual group was kept up to date through emails and maintaining the PPG web page on the practice site up to date. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice. The practice had analysed the results from the

Are services well-led?

Good

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

family and friends test completed between September and December 2014. A total of 102 patients had completed the standard question asked. Collated responses showed that 84.3% commented they were extremely likely to recommend the practice to family and friends, 14.7% were likely to recommend the practice and the remaining 1% felt they had not been at the practice long enough to long enough to say.

The practice actively gathered feedback from staff through the quality monitoring process, staff events, staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

The practice had a strong ethos of training, education and development. This ethos was evident throughout the practice. The practice manager had a nursing background with experience as a nurse tutor and was very keen to see all staff develop within their roles. All staff had undertaken training appropriate to their role and completed mandatory training. This was identified in staff appraisals which all staff had received. One of the GPs was the educational lead for the CCG and also for the out of hours provider. Online training was available to all staff regardless of their role.

The practice was an accredited training practice for GP trainees and for medical students from the local medical school and University College London. Plans were in place for student nurses from Stafford University to commence placements with the practice in September 2015. The practice would be the first in Shropshire to offer these placements. The practice counsellor offered placements to counselling students undergoing counselling training. A student who completed their placement in 2014 had completed their training and was working at the practice in a voluntary capacity.

The practice vasectomy surgeon had recently trained another GP to undertake vasectomy surgery at the practice. This had been planned as part of succession planning at the practice. This would enable the practice to continue providing this service for patients registered at the practice and patients from other practices, including other CCG areas where the service was not provided.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The staff personal and training files we looked at demonstrated that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected learning time where guest speakers and trainers attended. We saw that there was also a system of support for nurses and healthcare assistant and this role was fulfilled by the GPs. We saw that the practice had a training matrix that identified when staff training would need to be updated.

In the last six months staff had attended training in safety and quality. This was a programme delivered by an external company. As a result the practice had adopted the system of process mapping which enabled all staff to contribute to changes identified as needing review and change. This process had provided the practice with a system to comprehensively review significant events. The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients. We saw minutes that confirmed this.