

The Meadows Medical Practice

Quality Report

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Date of inspection visit: 26 October 2015

Date of publication: 10/12/2015

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

Ratings

Overall rating for this service		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Outstanding	
Are services responsive to people's needs?		Good	
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 The Meadows Medical Practice on 26 October 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- The practice's rural community dispensary and practice also provided the addition of a pharmacy in response to meeting the needs of their local community.
- 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.

Summary of findings

- Patients said they found it easy to make an appointment with a named GP and that there was excellent continuity of care, with urgent appointments available the same day, as well as a walk in and wait service each morning.

We saw several areas of outstanding practice including:

- The practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced use of the GP out-of-hours service and very positive patient survey results.
- The practice had systems in place that reflected best practice in end of life care and demonstrated an ethos of caring and striving to achieve a dignified death for patients. This was actively supported by practice staff and local community initiatives.
- The practice was presented with significant challenges in time management, patient transport services and responded effectively to support their patients. Mobile telephone and email signals were not always reliable in the remote rural locations the practice covered, which was an area of approximately 200 square miles.

The practice staff supported patients by enabling continuity of care with little or no changes in staff for several years, local knowledge and staff awareness of their local community.

However there were areas of practice where the provider should make improvements:

- There should be a formalised assessment of risk in place where non-clinical staff that were trained to carry out chaperone duties had no criminal record checks through the Disclosure and Barring Service (DBS) in place.
- Consider making a hearing loop available for patients and an emergency call bell system for the patient toilet facility.
- Consider automated doors for patients with physical disability.
- Document the practice whistleblower policy and make this accessible to all staff.
- Consider documenting the practice business plan and strategy.

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?

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, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings. Patients found the staff to be extremely person-centred and felt they were treated with respect. Patients expressed confidence in the fact that they were listened to and referred for care and treatment appropriately. They told us they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do. Staff were committed to working in partnership with their patients to offer care that promoted patients dignity and respected their preferred care choices, such as preferred place of death.

Outstanding



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients

Good



Summary of findings

that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led. Staff were clear about the practice aims and objectives, ethos and vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as outstanding for the care of older people. The practice had systems in place that reflected best practice in end of life care and demonstrated an ethos of caring and striving to achieve a preferred place dignified death for patients. This was actively supported by practice staff and local community initiatives. The practice has been able to support, with an integrated care approach, many patients in fulfilling their wish to die at home, which was not exclusive to patients on end of life care pathways. We found that the practice staff were familiar with the needs of patients nearing the end of their life and would take the initiative to facilitate care provision in difficult circumstances.

The practice provided cover for a local community hospital which involved weekly MDT meetings and ward rounds, and the admission of patients when they arrived from home or were transferred for rehabilitation or end of life care closer to home.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Outstanding



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good 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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children

Good



Summary of findings

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, health visitors and school nurses.

Working age people (including those recently retired and students)

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

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and all had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

Practice staff told us that they considered risk factors such as patient's mental health in areas of rural isolation within the local catchment area. The practice supported the 43 patients with enduring mental health and we found that to date 87% had a care plan in place and had regular blood tests completed in the management of their medicines as well as having annual physical health checks. There were 25 patients with organic mental health, such as dementia and 87% had a care plan in place to date and had

Outstanding



Summary of findings

received regular face to face consultations. This showed significant improvement from the 2013/14 Quality Outcomes Framework (QOF) data of 75% patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months. The practice provided an in-house counsellor to support patients and a psychiatrist also provided clinical sessions at the practice. The practice were aware of the Mental Health Crisis Care Concordat which was a national agreement between services and agencies involved in the care and support of people in crisis. The Concordat outlines the work that was required at a national and local level so that organisations responding to people experiencing a mental health crisis work together collaboratively and that these agencies had a shared understanding of the local processes needed to deliver high quality crisis care. This included access to support before crisis point, making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously. The practice had advertised this access within the waiting room and on the doors of the practice entrance.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published July 2015 showed the practice was performing better than or in line with local and national averages. There were 133 responses received giving a response rate of 52.8%.

- 100% find it easy to get through to this practice by phone compared with a Clinical Commissioning Group (CCG) average of 85% and a national average of 73%.
- 98.3% find the receptionists at this practice helpful compared with a CCG average of 90.1% and a national average of 86.8%.
- 72.7% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 62.9% and a national average of 60.0%.
- 92.6% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88.4% and a national average of 85.2%.
- 94.4% say the last appointment they got was convenient compared with a CCG average of 94.1% and a national average of 91.8%.

- 90.7% describe their experience of making an appointment as good compared with a CCG average of 82.1% and a national average of 73.3%.
- 63.9% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 64.9% and a national average of 64.8%.
- 70.5% feel they don't normally have to wait too long to be seen compared with a CCG average of 60.8% and a national average of 57.7%.

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 44 comment cards which were all positive about the standard of care received. Forty comment cards described the service as excellent. Comments were extremely positive about the knowledge, kindness and professionalism of the clinical staff and finding the practice staff caring, polite, friendly and welcoming. Four made additional comments such as the longer waiting time on occasion to be seen, but understood the reason why, as they felt it was because the GPs spend time listening to patient's needs.

The Meadows Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **Care Quality Commission (CQC) Lead Inspector**. The team included a GP specialist adviser, a new CQC inspector shadowing the first half of the inspection, a practice manager specialist adviser and an Expert by Experience.

Background to The Meadows Medical Practice

The Meadows Medical Practice is located in Clun, Craven Arms, Shropshire with a branch location in Knighton, Wales. It is part of the NHS Shropshire Clinical Commissioning Group. All of the practice patients, including those in Knighton, come under the auspices of Shropshire CCG and NHS England. They are in a remote rural locality covering an area of approximately 200 square miles. This can present significant challenges for the practice with secondary care providers and transport services. Knighton has a railway station that connects services to Craven Arms and Shrewsbury, but Clun has no public transport at all, and is situated in a remote valley surrounded by hills. Patients who cannot drive can be at risk of extreme isolation. The practice covers all the surrounding villages and many very isolated rural hillside farms. The practice has on occasion required air ambulance support for their patients.

The total practice patient population is 3,707. The practice has a higher proportion of patients aged 65 years and

above (46.1%) which is higher than the practice average across England (26.5%). It has a population which has a slightly percentage of patients with a long-standing health condition 58.4% when compared to the practice average across England (54%).

The staff team comprises a male and two female GP partners. The practice team includes two part time practice nurses, two part time healthcare assistants, a lead dispenser and two dispensing staff, a practice manager, office manager and five receptionists/administrative support staff. In total there are 17 staff employed either full or part time hours. The practice operates with one GP and one nurse at each site (Clun and Knighton) plus reception and dispensing staff.

The practice at both locations is open Monday to Friday 8.30am to 6pm. The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed through Shropdoc, the out-of-hours service provider. The practice telephones switch to the out-of-hours service at 6pm each weekday evening and at weekends and bank holidays.

The practice provides a number of clinics, for example long-term condition management including asthma, diabetes and high blood pressure. It also offers child immunisations, minor surgery, tele dermatology (the use of photography to gain a diagnosis using a dermatoscope, the results are emailed to secondary care). The practice offers a walking/ exercise group health checks and smoking cessation advice and support. The practice operates a dispensary from its Clun location and a limited GP led dispensing service from its Knighton location.

Detailed findings

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract for the practice to deliver general medical services to the local community or communities. They also provide some Directed Enhanced Services, for example they are a dispensing practice, offer minor surgery and the childhood vaccination and immunisation scheme and for their patients.

Why we carried out this inspection

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

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 26 October 2015. During our visit we spoke with a range of staff which included the practice manager, dispensary staff, office manager, receptionists, two GPs and we spoke with nine patients who used the service and a member of the PPG. 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 44 comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. Any patients affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager or GPs of any incidents. Although there was not a standardised template for significant events there was an effective colour coded recording system in place based on severity of risk which was RAG rated (red, amber and green). All events were summarised on the practice's computer system. All complaints received by the practice were recorded and treated as significant events. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a nebuliser mask was needed for a patient and the staff found that there were no suitable masks available. (A nebuliser delivers a medicine/ aerosol mist which can be inhaled via a mask or a mouthpiece). The masks ordered by staff were unsuitable for the treatment required. Once investigated it was found that it was a human error and the learning outcome was that an essential items list was made, with a six monthly stock check which was signed and dated by staff and to check that the stock ordered was received.

The practice prioritised safety and used a range of information to identify risks and improve patient safety, including National Institute for Health and Care Excellence (NICE) guidance.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended external safeguarding

meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.

- A notice was displayed in the waiting room, advising patients of the chaperone service, if required. All clinical and non-clinical staff who acted as chaperones were trained for the role. All clinical staff had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice carried out an informal risk assessment in respect of reception staff that also carried out chaperone duties. We were assured that this would be formalised and/or non-clinical chaperone staff be in receipt of DBS checks.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy and poster available within the practice. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure it was safe to use and clinical equipment was tested to ensure it was accurate. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. We found that the practice had sphygmomanometers (for measuring blood pressure) and needed to obtain a mercury disposal kit in the event of spillage.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received training. Infection control audits were undertaken the last audit took place in August 2014 and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out to ensure the

Are services safe?

practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

- The practice had a dispensary service at the Clun practice. This was managed with two qualified dispensary staff and a dispensary manager. We were informed by the GP partners that the Knighton practice had a GP only dispensing service which offered a site specific limited medicine stock.
- There was a system in place for the management of high risk medicines such as disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. There were arrangements in place for the destruction of controlled drugs.
- Recruitment checks were carried out and the four files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment for the most recently recruited staff. One file reviewed did not contain a copy of the staff members' photographic proof of identification or a full employment history, but the staff member had a SMART card with a photograph.

Checks such as references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service were all contained within the files reviewed.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice also had a staffing policy in place, which highlighted the importance of having adequate staffing levels at both practice sites at all times, with an appropriate skill mix of staff to maintain the quality of care and safety for patients.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to an emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice results were 93.2% of the total number of points available, with 3.7% all domains exception reporting. We found the practice clinical exception reporting to be 0.2 percentage points below CCG average and 0.4 below the England average. (The QOF includes the concept of exception reporting to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a side-effect).

The practice performance for diabetes in five out of the six related indicators was similar to the Clinical Commissioning Group (CCG) and national averages. The one area for improvement showed that the percentage of diabetic patients with a specific blood pressure reading was 60.94% compared to the national average of 78.53%. When this was explored it was found to be an electronic coding issue.

The practice data from 2014/15 also illustrated they were not an outlier for national clinical targets;

- The percentage of patients with hypertension regular blood pressure tests was similar to the national average. For example, the percentage of patients with

hypertension in whom the last blood pressure reading measured in the preceding 9 months within accepted levels was 83.78% when compared to the national average of 83.11%.

- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients with physical and/or mental health condition whose notes recorded their smoking status in the preceding 12 months was 93.46% compared to the national average of 95.28%.
- The dementia diagnosis rate was comparable to the national average. For example, the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 85% compared to the national average of 83.82%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been eleven clinical audits completed in the last 12 months. We reviewed two of these audits where the improvements made were implemented and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, recent action taken as a result included an audit into patients with chronic obstructive pulmonary disease (COPD) 'Just in Case' medicines in 2014 and the reaudit in April 2015. (COPD is the name for a collection of lung diseases). The results show that there had been an improvement with greater numbers of patients having a management plan and taking their medicines appropriately.

Information about patients outcomes was used to make improvements such as;

- Creating accurate registers of the percentage of patients with confirmed Left Ventricular Systolic Dysfunction (LVSD) changed from 57% to 88%, (LVSD is a form of heart failure condition caused by the heart failing to pump enough blood around the body at the right pressure). This also raised the profile of heart failure patients in the practice and all clinician's reviewed the current guidance to improve treatment of this condition.

Are services effective?

(for example, treatment is effective)

The GPs used the process of gradually adjusting the dose of medicines until optimal results were reached for each patient. They found they were able to make accurate diagnoses without referral to secondary care.

- Audit of tele dermatology referrals for skin lesions, demonstrating a reduction in the number of referrals into secondary care and reduction in the requirement for patients to have to travel to hospital. The internal audit demonstrated that this service avoided referral to hospital for 31% of patients seen over a 15 month period.
- Number of prescribed Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) as a percentage of all Items prescribed was lower (66.36%) when compared to other practices (national average 75.13%).
- The number of emergency admissions per 1,000 population in the period January 2014 to December 2014 was lower (10.15) when compared to the national average (14.4). Therefore the reduction in the requirement for patients to have to travel to hospital and evidenced the support the practice provided in managing patients' conditions well to avoid a medical crisis.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring and facilitation and support for the revalidation of GPs. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules, in-house training and protected learning events with their local CCG.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when patients were referred to other services.

Staff worked together and with other health and social care services, to understand and meet the range and complexity of patient's needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team (MDT) meetings took place on a regular basis and that care plans were routinely reviewed and updated. The practice also provided cover for a local community hospital which involved weekly MDT meetings and ward rounds, and the admission of patients when they arrived from home or were transferred for rehabilitation or end of life care closer to home.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were also signposted to relevant support groups. Smoking cessation advice was available locally. The

Are services effective?

(for example, treatment is effective)

practice staff told us that communication with the community was the key to health promotion and prevention, and they had a regular column in the Clun Chronicle, a monthly publication which covers all the surrounding villages. This included the latest news from the practice and topical health promotion articles.

Clun has four established walking groups in collaboration with Shropshire Council. The practice supported the establishment of a 'Walking for Health' group for those who needed encouragement to take the first steps and they now meet regularly on Tuesdays walking from and returning to the local café. For example, one of their older patients had, following a recent diagnosis, reduced their attendance at the Ramblers (15 mile walks) to the Peramblers (10 mile walks).[GR1]

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 79.7% which was comparable to the national average of 81.88%. There was a policy to offer telephone reminders

for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were slightly lower when compared to national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 86.7% to 100% and five year olds from 75% to 83.3%.

Flu vaccination rates for the over 65s were 71.64%, and at risk groups 56.23%. These were comparable to the national averages.

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



Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that patients were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 44 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We spoke with a member of the patient participation group (PPG) on the day of our inspection. They also told us they were very satisfied with the care provided by the practice and that staff respected patient's dignity and privacy. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was well above the national average for its satisfaction scores on consultations with GPs and nurses. For example:

- 100% said they had confidence and trust in the last GP they saw compared to the CCG average of 97.1% and national average of 95.2%.
- 95.5% said the GP was good at listening to them compared to the CCG average of 92.9% and national average of 88.6%.
- 93.9% said the GP gave them enough time compared to the CCG average of 92% and national average of 86.6%.
- 92.7% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90.4% and national average of 85.1%.
- 91.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93.4% and national average of 90.4%.

- 98.3% patients said they found the receptionists at the practice helpful compared to the CCG average of 90.1% and national average of 86.8%.

The practice were able to offer numerous examples of how they supported patients in their community with respect, dignity, compassion and empathy. One patient for example required help from the local 'Good Neighbours Scheme,' food from the emergency larder (CommunityLarder@Clun), regular appointments with a consultant Psychiatrist who provided clinics in the practice and sessions with the practices' in-house counsellor. The patient's emotional and physical well-being was being supported by the practice and local community. The patient responded well and developed a creative talent and presented as a means of thanks staff with handmade gifts. Other examples:

- Many patients spend their entire working lives outdoors and the practice accommodates seasonal variations and occupational hazards. For example, in lambing season farmers work long hours often through the night and the practice see an increase in respiratory infections, exhaustion and shoulder injuries. The practice staff had insight into their patients occupational seasonal risks which also included Actinic keratosis (sun damage which is a precursor to skin cancer) which is common.
- In the recent past one patient had arrived at the practice after being kicked by a horse in the face, had fallen to the ground, was temporarily knocked out and when they regained consciousness had driven to the practice. (There is no mobile phone reception for much of the practice catchment). The receptionist calmly ushered them into the treatment room onto the couch and sent the GP an alert message. The GP assessed the patients' conscious level and the extent of the facial injuries, all while delaying booked appointments, and then transferred the patient to hospital and arranged emergency care for the patient's dog.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and



Are services caring?

had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 92.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90.6% and national average of 86.0%.
- 92.7% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 90.4% and national average of 85.1%.

Staff told us that translation services were available for patients who did not have English as a first language. The practice had very few patients from ethnic minority groups.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told 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. There was a practice register of all people who were carers and they would be supported, for example, by offering health checks and where appropriate referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

The practice has a high percentage of patients over the age of 65, most of whom have lived in the area all their lives. This includes the farming population who have occupied

remote hill farms for generations, but now often into their nineties are becoming increasingly frail, isolated, unable to drive, and whose families have moved away to find work elsewhere. These patients want to remain at home at all cost and this presents challenges in care provision. The practice carried out home visits which can be many miles apart and have very good communications with district nurses and clinical nurse specialists from local hospices. The practice has been able to support, with an integrated care approach, many patients in fulfilling their wish to die at home, which was not exclusive to patients on end of life care pathways. For example from the period October 2014 to October 2015 there had been 36 patient deaths, of these 10 patients were on the Gold Standard Framework (GSF), and 26 were not, eight non GSF patients were supported by the practice to enable the patients choice of a peaceful home death. (GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life). The practice could refer to a Hospice at Home service offering nursing care outreach for both night and daytime care for patients at the end of life and this service could be mobilised on the day of referral, avoiding otherwise inevitable hospital admission. The practice place 'Just in case' drugs in the patients home for terminally ill patients and shared all special patient records with the out-of-hours provider for continuity of care. We found that the practice staff were familiar with the needs of patients nearing the end of life and would take the initiative to facilitate care provision in difficult circumstances.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a consultation at a flexible time and location to meet the family's needs and/or by giving them advice on supportive services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice offered a 'Walk in' service Monday, Wednesday and Friday for patients arriving between 8.30am and 10am.
- There were longer appointments available for patients with a learning disability. The practice maintained a learning disability register and link with the Shropshire learning disability service. Most of the practice staff lived within the local community and so were aware of vulnerable patients and able to highlight issues that might not otherwise have come to light. An example included an older patient without a phone, limited mobility, and significant health problems declined carer support. The practice GP and patient agreed that a local 'good neighbour' volunteer could be a conduit for communication with the practice, and if necessary carry messages.
- The practice has a domestic violence policy and could access a local refuge in cases of domestic violence.
- Home visits were available for older patients and patients who would benefit from these such as vulnerable and terminally ill patients.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities and translation services available. However, the practice entrance did not have automated doors for patients with physical disability.
- The practice offered a 'one-stop shop' for multiple conditions to minimise the inconvenience of multiple practice visits.
- Patients with long term conditions, with poor control or complications could be booked into dedicated GP appointment slots alongside the patient's appointment at the long term condition clinic run by the nurses.
- Patients had direct input from the Community Specialist Diabetic Nurse who completed on-site clinics at the Knighton location. Knighton also has a 'Leg Club' each

Thursday morning, managed and run by the district nurses. Patients had access to education and self-help programmes for example STILE (Shropshire Titration of Insulin and Lifestyle Education).

- Patients with lung disease had access to pulmonary rehabilitation and those with severe chronic obstructive pulmonary disease (COPD) had direct access to respiratory nurses by telephone and they also offered home visits. The moderate and severe COPD patients kept a reserve supply of antibiotics and steroids as per their care management plans. (COPD is the name for a collection of lung diseases).
- The care of Gay, Lesbian, Bisexual and Transgender (GLBT) patients, many of whom fall into the older patient group registered at the practice.
- The practice's rural community dispensary and practice also provided the addition of a pharmacy in response to meeting the needs of their local community.
- Practice staff told us that they considered risk factors such as patient's mental health in areas of rural isolation within the local catchment area. The practice supported 43 patients with enduring mental health and we found that to date 87% had a care plan in place and had regular blood tests completed in the management of their medicines as well as having annual physical health checks. There were 25 patients with organic mental health, such as dementia and 87% had a care plan in place to date and had received regular face to face consultations. The practice provided an in-house counsellor to support patients and a psychiatrist also provided clinic sessions at the practice. The practice were aware of the Mental Health Crisis Care Concordat which was a national agreement between services and agencies involved in the care and support of people in crisis.
- The practice shared out of date sterile wrapped gallipots and plastic scissors for art activity resources with local primary schools and shared out of date equipment and unused medicines with Medic Malawi, a locally based charity that takes the supplies directly to a health facility in Malawi.
- The staff undertook training for the local Carnival Fell Run and entered a team of five runners (plus five family members) and raised £760 for Water Aid.

Are services responsive to people's needs?

(for example, to feedback?)

- An Arts Alive cycling event was held in the village in 2014, with 50 and 100 mile rides and a whole day related to all sorts of cycling with fun activities for children. One of the GPs provided voluntary first aid cover for the whole day (fortunately not needed).

Access to the service

The practice was open between 8.30am-6pm Monday to Friday. The practice operated a walk in service Monday, Wednesday and Friday for patients arriving between 8.30am and 10am. The practice had found that extended hours surgeries were not a priority to the majority of their registered population. In addition patients could make pre-bookable appointments in advance and urgent appointments were available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was in most cases better than local and national averages and people we spoke with on the day were able to get appointments when they needed them. For example:

- 89% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 74.9%.
- 100% patients said they could get through easily to the practice by phone compared to the CCG average of 85% and national average of 73.3%.
- 90.7% patients described their experience of making an appointment as good compared to the CCG average of 82.1% and national average of 73.3%.
- 63.9% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64.9% and national average of 64.8%.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system including a summary leaflet available. Patients we spoke with were aware of the process to follow if they wished to make a complaint. However, patients would need to ask reception for a complaint form as no forms were freely available in the waiting room area.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency in dealing with the complaint.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, a patient complained that staff had not followed up on their hospital results and felt there had been an undue delay. There were no adverse clinical implications to the delay. During the investigation it was found that the results had been received but had been filed under the wrong date. The situation was explained to the patient to their satisfaction. As a result of the complaint all results received were then filed under the date of receipt and not under the date of the original procedure.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice staff were unaware as to whether the practice had a written mission statement but staff knew and understood the practice ethos and values. The practice strategy was to continue to provide a safe, quality service to their patients and local community. The practice did not have a documented business plan but held regular meetings as partners, management and staff meetings to monitor, learn and where necessary improve service provision to their patients. Staff said they put patients at the heart of everything they did.

Governance arrangements

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

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

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that there was an open culture within the practice. Staff had the opportunity to raise any issues at regular team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice. The practice did not have a documented whistleblower policy which was accessible to all staff. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG set up four years ago with a mailing list of around 180 patients which met on a six monthly basis, they carried out patient surveys and if the need arose submitted proposals for improvements to the practice management team. For example, the GP and PPG had discussed the publication of Future Fit and the challenges they face, such as succession planning in a rural community. The practice also had a patient participation committee which met 10 times a year.

The practice had also gathered feedback from staff through staff away days and generally through staff meetings, appraisals, discussion and when they fund raise for the local community. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. There was a strong focus on continuous learning and improvement at all levels within the practice.