

Mytton Oak Medical Practice

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Mytton Oak Medical Practice on 14 June 2016. Overall the practice is rated as good overall.

Our key findings were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice provided GP services to a Shrewsbury school, which has boarders who may be from overseas without English as their first language, and held a daily surgery on the school site.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

There were areas of practice where the provider should make improvements:

- Consider how staff immunity records are held and maintained.
- Implement a system to formally monitor and verify staff's registration with their professional body.

Summary of findings

- Carry out regular fire drills and record the names of attendees.
- Consider implementing a staff training planner, including specialist training for clinical staff to enable oversight and governance.
- Consider staff training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS).
- Consider holding whole staff meetings.

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.

Good



- There was an effective system in place for reporting and recording significant events, improvement was needed in documenting the learning from events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safeguarded from the risk of abuse.
- There was a robust medication review system.
- Improvements were needed as the practice had not ensured that all recruitment checks had been completed prior to a clinical staff member's employment, however the staff member had had no patient contact. There was no formal system in place to monitor clinical staff's registration with their professional body. They did not hold records of some staff's health immunity status.
- Policies and procedures to support staff with current best practice had been regularly reviewed.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The GP had completed clinical audits and used findings as an opportunity to drive improvement.

Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The results from the January 2016 GP national patient survey demonstrated positive feedback in relation to the patients' experiences at the practice.
- The practice offered additional services for carers, although the overall number of carers was under review to ensure its accuracy.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.

Good



Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. An improvement would include a staff training planner, including specialist training for clinical staff to enable easier oversight and governance.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

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

Good



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

- The uptake of the shingles vaccination for the eligible age groups was 74%.
- The percentage of patients who lived in a care home setting of the 10,198 patients registered was 0.65%, (67) patients. All patients had a care plan and these had been reviewed at least annually.
- The practice offered proactive, personalised care to meet the needs of the older people in its population. They were responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had an associated part-time care coordinator who for example could refer patients who were isolated and in need of support, provide information and signposting to other services and could organise day centre and support for carers.
- The practice participated in the local enhanced service for the avoidance of unnecessary admissions to hospital. Care plans for these patients were reviewed on an annual basis. Patients were discussed at regular multi-disciplinary team meetings, with their own GP being responsible for coordinating their care.
- The practice engaged with the 'Good Neighbours' scheme associated with the practice. This was a group of patients who worked on a voluntary basis to provide transport to appointments and some non-clinical support services to older patients. They also fundraised for the practice and transformed the flu vaccination clinics into more of a social event.

People with long term conditions

Good



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

- Patients at the highest risk of unplanned hospital admissions were identified and care plans had been implemented to meet their health and care needs.

Summary of findings

- 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 medicines needs were being met. For people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Nursing staff had lead roles in chronic disease management and had undertaken additional training. For example, all newly diagnosed diabetics were referred to a local 'Expert Programme' and patients with Chronic Obstructive Pulmonary Disease (COPD) were referred locally for pulmonary rehabilitation. COPD is the name for a collection of lung diseases including chronic bronchitis.

Families, children and young people

Good



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. For example, on a monthly basis a search was completed for A&E attendances and their GP informed about any child who attends on four or more occasions in one year and of any attendance by a child known to be at risk.
- 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.
- The practice uptake of flu vaccinations in pregnant women was 63%, where there was no other risk, and 86% where patients had identified additional risks.
- The practice's uptake for the cervical screening programme was 80% which was comparable with the CCG average of 83% and national average of 82%.
- The practice was young person-friendly and offered condoms, pregnancy testing and chlamydia testing for all aged 15-24.
- The practice provided GP services to a Shrewsbury school and held a daily surgery on the school site.

Summary of findings

- The practice nurses ran immunisation clinics and patients who did not attend these clinics were followed up by the practice and referred to the health visitor.

Working age people (including those recently retired and students)

Good



The practice is rated as good for the care of working-age people (including those recently retired and students).

- The practice offered extended hours evening appointments from 7.30am on Mondays, Tuesdays and Wednesdays, and an appointment only surgery on one Saturday each month. .
- The practice provided online services to enable patients to book appointments, order repeat medicines and access some parts of their health records online.
- Health promotion and screening services reflected the health needs of this group.
- Patients were able to request telephone advice/consultation and the response to this was made the same day, or the evening of the request.
- 57% of eligible patients had been invited for an NHS health check and 27% of eligible patients had attended to date.

People whose circumstances may make them vulnerable

Good



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

- The practice held a register of patients living in vulnerable circumstances including known vulnerable adults, those who were housebound and patients with a learning disability. For example, the practice supported a local residential school for children with learning and behavioural difficulties and the GPs provided annual medicals and prescriptions in line with shared care agreements.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- The practice held a register of the practices' frail and vulnerable patients and had identified patients who may be at risk of unplanned hospital admissions.
- The practice facilitated patients requiring GP services with drug and alcohol rehabilitation needs.
- The practice associated care co-ordinator supported patients and signposted to other allied health and social care professionals, voluntary agencies and charitable agencies when required.
- The practice provided GP services to a Shrewsbury school, which has boarders who may be from overseas without English as their first language and held a daily surgery on the school site.

People experiencing poor mental health (including people with dementia)

Good



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

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice had 99 patients on their mental health register, 88% had care plans agreed and to date 86% had had an annual review. All patients prescribed a particular medicine used to treat bipolar disorder, manic-depressive illness had had appropriate blood tests completed.
- There were 79 patients on the patient dementia register at the practice and of these 80% had been in receipt of a care plan review in the previous 12 months.
- Patients living with poor mental health were encouraged to see the same GP and there were systems in place to facilitate this. Patients who were diagnosed with depression, known to be vulnerable or who missed appointments were then phoned by the GP who knew them.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included comments made to us from patients and information from:

- The national GP patient survey published in January 2016. The survey invited 235 patients to submit their views on the practice, a total of 121 forms were returned. This gave a return rate of 51%.
- The practice worked with the patient participation group (PPG) and the practice manager attended each meeting.
- We invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 17 completed cards.

In the national GP survey, patient satisfaction was positive in areas relating to interaction with nurses, reception, opening hours and overall experience. Satisfaction levels were less positive in the areas of making an appointment and interaction with GPs.

The feedback we received from patients about the practice care and treatment was positive. Themes of positive feedback included:

- The helpful, caring, compassionate and professional nature of staff and the new practice environment.
- Overall good or excellent experience of the practice.

Mytton Oak 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 also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

Background to Mytton Oak Medical Practice

Mytton Oak Medical Practice is registered with the Care Quality Commission as a partnership provider, which includes six GP partners. The provider holds a General Medical Services contract with NHS England. At the time of our inspection 10,198 patients were registered at the practice. The practice, in line with the local Clinical Commissioning Group (CCG), has a higher proportion of patients aged 65 years and over when compared with the practice average across England. For example, the percentage of patients aged 65 and above at the practice is 20%; the local CCG practice average is 24% and the national practice average, 17%. The practice population has a higher percentage of male 15 to 19 year olds and is slightly higher in this age group for females.

Mytton Oak Medical Practice is located in a purpose built building. As well as providing the contracted range of primary medical services, the practice provides additional services including:

- Minor surgery
- Venepuncture (blood sample taking)

The practice is open each weekday from 8am to 6pm. Extended hours are provided from 7.30am on Monday,

Tuesday and Wednesday and they provide an appointment only surgery held on one Saturday each month. The practice has opted out of providing cover to patients outside of normal working hours. The out-of-hours services are provided by Shropdoc which includes the margins between 8am and 8.30am and 6pm and 6.30pm.

Staffing at the practice includes six GP Partners (two male, four female) and at the time of the inspection a GP registrar. The clinical staff includes; a newly recruited advanced nurse practitioner, a lead nurse and two practice nurses, as well as a healthcare assistant. The practice management includes a practice manager, and two patient service managers. The practice is supported by a Quality and Outcomes Framework (QOF) and clinical governance lead, two data entry administrators, eight reception staff and a community and care co-ordinator. There are 29 staff in total, working a mixture of full and part times hours.

Why we carried out this inspection

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

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:

Detailed findings

- 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 our inspection we reviewed the information we held about the practice. We also reviewed intelligence including nationally published data from sources including Public

Health England and the national GP Patient Survey. We informed NHS England and NHS Shropshire Clinical Commissioning Group that we would be inspecting the practice and received no information of concern.

During the inspection we spoke with members of staff including GPs, a practice nurse, care co-ordinator, the managing partner/practice manager, reception and administrative staff. We also spoke with a member of the patient participation group (PPG). (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services).

- We observed how patients were being cared for and talked with carers and/or family members.
- We reviewed an anonymised sample of 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.

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.

Are services safe?

Our findings

Safe track record

The practice operated an effective system to report and record significant events.

- Staff knew their individual responsibility, and the process, for reporting significant events.
- Significant events had been thoroughly investigated. When required action had been taken to minimise reoccurrence and learning had been shared within the practice team.
- Significant events were discussed at practice meetings.
- All occurrences were reviewed and trend discussion/analysis took place and when needed changes were made to promote a safe culture.
- Improvement was needed in documenting the learning from events in some but not all of those reviewed.

We reviewed records, meeting minutes and spoke with staff about the measures in place to promote safety. Staff knew the processes and shared recent examples of wider practice learning from incidents. For example, since the introduction of electronic prescribing (EPS) at the practice, a number of errors had been identified such as when a patient had changed from one medicine to another within the same group of medicines. The potential risk in one case was that the patient may have taken both rather than one of the medicines. The GPs investigated each incident with the involvement of the pharmacists and identified specific actions and learning outcomes as a direct result. The risk, once identified, was rectified on the practice's electronic systems and the learning from this shared with staff.

The practice had a process in place to act on alerts that may affect patient safety, for example from the Medicines and Healthcare products Regulatory Agency (MHRA). These were discussed with GPs who demonstrated clear knowledge on the most recent alerts.

A culture to encourage duty of candour was evident through the significant event reporting process. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific

requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Overview of safety systems and processes

The practice had a number of systems in place to minimise risks to patient safety.

- The practice had policies in place for safeguarding both children and vulnerable adults that were available to all staff. All staff had received role appropriate training to nationally recognised standards. A GP was identified as the safeguarding lead within the practice. The staff we spoke with knew their individual responsibility to raise any concerns they had and were aware of the appropriate process to do this. Staff were made aware of both children and vulnerable adults with safeguarding concerns by computerised alerts on their records. Each consulting, treatment and reception area had access to the appropriate safeguarding contact details. The practice manager assured us that where the safeguarding policy needed to be amended this would be completed, to ensure that the blank areas left for practice specific details were completed.
- Chaperones were available when needed. All staff who acted as chaperones had received appropriate training, had a disclosure and barring services (DBS) check and knew their responsibilities when performing chaperone duties. 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. Only clinical staff at the practice completed chaperone duties.
- The practice was visibly clean and tidy and clinical areas had appropriate facilities to promote the implementation of current Infection Prevention and Control (IPC) guidance. IPC audits had been undertaken in both February and June 2016 actions required as a direct result were either in progress or planned.
- We found that the records in respect of staff immunity to healthcare associated infections were not held and therefore there was no oversight on individual staff immunity status. It was clear that the practice manager and IPC lead each thought the other held this information. During the course of the inspection the IPC lead staff member had identified that GP staff held their

Are services safe?

own records which would verify their immunity and the practice manager confirmed that all clinical staff had attended an occupational health appointment as part of their recruitment process, and it was assumed that staff immunity checks would have been undertaken.

- The practice followed nationally recognised guidance and legislative requirements for the storage of medicines. This included a number of regular checks to ensure medicines were fit for use. The practice nurses used Patient Group Directions (PGDs) to allow them to administer medicines in line with legislation. Blank prescriptions were securely stored and there were systems in place to monitor their use. Staff ensured there were adequate stocks of medicines for example in the use of children's immunisations and travel vaccines. They monitored expiry dates and rotated medicine stocks as necessary.
- The GPs did not routinely hold medicines in their bags. The practice had invited a review of their safe handling of medicines to ensure they met the required standards. They had overhauled their storage of medicines, their key holder arrangements for the medicine cabinets, and set up safe systems in respect of GP boxes for GPs to take on home visits when required. These GP boxes were well managed and there was an effective and safe medicines management system in place, which included booking these boxes in and out of the practice.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice employed a Quality and Outcomes Framework (QOF) and clinical governance lead who ran regular checks and contacted patients to ensure they attended for their appropriate regular medicine management review checks. The practice carried out regular medicines' audits, with the support of the local CCG medicine management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- We reviewed five personnel files and found appropriate recruitment checks had not been undertaken prior to employment for a recent clinical recruit. For example, there was no proof of qualifications or registration with the appropriate professional body or the appropriate checks through the Disclosure and Barring Service. We discussed this with the practice manager who informed us that the staff member was not providing any clinical

duties during their induction with the practice. They assured us that the appropriate checks would be completed prior to the staff member commencing clinical duties and a risk assessment in the interim period would be completed. The practice had medical indemnity insurance arrangements in place for relevant staff. There was no system in place to monitor and verify staff's registration with their professional body.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives. The practice had up to date fire risk assessments but had not carried out regular fire drills. This had been identified by the practice manager as an area which required action and had planned for a fire drill to take place on 28 June 2016.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs.
- Regular infection control audits were held. The practice was unable to evidence if all staff at the practice were immunised against appropriate vaccine preventable illnesses.

Arrangements to deal with emergencies and major incidents

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

- Staff had received annual update training in basic life support in November 2015.
- The practice had emergency equipment accessible within the building. This included an automated

Are services safe?

external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm), oxygen and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).

- Emergency medicines were held to treat a range of sudden illness that may occur within a general practice. Medicines were stored securely and staff knew their location. The practice emergency medicines checks completed by staff included expiry date monitoring.
- An up to date business continuity plan detailed the practice response to unplanned events such as loss of power or water system failure.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Changes to guidelines were shared and discussed at practice learning and training events/ meetings, clinical meetings as well as frail and vulnerable and palliative care multi-disciplinary team meetings.
- The practice monitored that these guidelines were followed through risk assessments and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). QOF results from 2014/15 showed that within the practice:

- The practice achieved 94% of the total number of points available; this was comparable with the national average of 95% and clinical commissioning group (CCG) average of 97%. We were shown the 2015/16 as yet unpublished results which showed the practice had further improved and achieved 549.16 points out of 559 (98%).

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

- Performance for poor mental health indicators was slightly lower than the national averages. For example, 77% of patients with severe poor mental health had a recent comprehensive care plan in place compared with the CCG average of 89% and national average of 88%. Clinical exception reporting was higher at 14%, when compared with the CCG average of 12% and national

average of 13%. Clinical exception rates allow practices not to be penalised, where, for example, patients do not attend for a review, or where a medicine cannot be prescribed due to side effects.

- Performance for diabetes related indicators was similar to local and national averages. For example, 80% of patients with diabetes had received a recent blood test to indicate their longer term diabetic control was below the highest accepted level, compared with the CCG average of 80% and national average of 78%.

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

- A practice nurse who was completing the specialist diabetic nurse training, supported diabetic patients with dietary advice, referred patients to a structured education program, a foot screening service and a retinal screening service when they were first diagnosed. The nurse had completed an audit on the effect of weight loss on the blood sugar levels in patients with type 2 diabetes. Of the 24 patients who received intensive diet and lifestyle education on at least one occasion, 21 had lost weight; seven had resolved obesity and 16 had reduced their blood sugar levels. A repeat audit in six months' time was planned.
- The practice participated in the avoiding unplanned admission enhanced service. Two per cent of patients, many with complex health or social needs, had individualised care plans in place to assess their health, care and social needs. Patients were discussed with other professionals when required and if a patient was admitted to hospital their care needs were reassessed on discharge.
- When patients were admitted to hospital, the practice established when they were discharged home or due to be discharged, and the community and care co-coordinator at the practice contacted them within 48 hours for an initial post hospital discharge review, to ensure their needs could be met.

The practice performance between 2014/15 for the number of emergency admissions for 19 ambulatory care sensitive conditions per 1,000 of the population was 18.7 which was slightly higher but comparable with the CCG average of 13.75 and national average of 14.6. Ambulatory care sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute episodes and reduce the

Are services effective?

(for example, treatment is effective)

need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions.

The practice was working with the primary support medicines management team on the practice performance on prescribing medicines. They were in receipt of a report based on their prescribing data between 2015/2016 from NHS Shropshire Clinical Commissioning Group, Prescribing Quality and Optimisation Scheme (PQOS). The practice engaged with the medicines management team who supported them in ensuring best practice in medicine optimisation and prescribing and in the monitoring and auditing for example, in antibiotic prescribing levels within the practice.

There had been a number of two cycle clinical audits undertaken. We looked at two, one of which looked at patients aged 18-80 with type 2 diabetes mellitus. The repeat audit cycle demonstrated an improvement in some standards, for example, the practice had performed above average by achieving a blood pressure equal or below a specific target reading in 63% of patients, when compared to those in The National Diabetes Audit. This was also an improvement on the achievement in 2013 which was 57%. This showed a 6% improvement in one year but was still below the QOF target of 78% for 2014. There were recommendations for changes in practice made following these audits which had been implemented and were being monitored.

Effective staffing

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

- The practice had reviewed its access provision and staff skill mix within the practice to account for the risk of any future recruitment difficulties.
- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The locum GP induction pack was reviewed which provided clear and relevant information.
- The learning needs of staff were identified through appraisals, and staff told us they felt supported.

- 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 and in-house training.
- The practice was a GP training practice.

Working with colleagues and other services

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. When patients required referrals for urgent tests or consultations at hospitals, the practice monitored the referral to ensure the patient was offered a timely appointment.
- The practice team met with other professionals to discuss the care of patients that involved other allied health and social care professionals. This included patients approaching the end of their lives, those at increased risk of unplanned admission to hospital and the practice identified frail and vulnerable patients. Minuted meetings took place on a monthly basis.

Consent to care and treatment

Staff sought patients' consent to care and treatment 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. However, some staff we spoke with could not recall whether they had attended or completed any specific training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Staff were aware of the importance of involving patients and those close to them in important decisions about when and when not to receive treatment.

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice offered a range of services in house to promote health and provided regular reviews for patients with long-term conditions:

- NHS Health Checks were offered to patients between 40 and 74 years of age to detect emerging health conditions such as high blood pressure/cholesterol, diabetes and lifestyle health concerns. The practice was able to demonstrate that of the eligible patients invited, 57% had attended, and of these, 58 patients had been identified as requiring a follow up appointment with their GP.
- The practice offered a comprehensive range of travel vaccinations including Yellow Fever and clinical staff had received role specific training.
- Immunisations for seasonal flu and other conditions were provided to those in certain age groups and patients at increased risk due to medical conditions.

- New patients were offered a health assessment with a member of the nursing team, with follow up by a GP when required.
- The practice's uptake for the cervical screening programme was 80% which was slightly lower than the CCG average of 83% and national average of 82%.

Data from 2014, published by Public Health England, National Cancer Intelligence Network Data showed that the number of patients who engaged with national screening programmes was?? when compared with local and national averages:

- 72% of eligible females aged 50-70 had attended screening to detect breast cancer. This was slightly lower than the CCG average of 77% but the same as the national average of 72%.
- 67% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer. This was better than the national average of 58% and local CCG average of 62%.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

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

We received 17 completed cards, 16 of which were positive about the caring and compassionate nature of staff. One comment noted they found the management to be too rigid with set ideas and that they did not listen to patients, which we fed back to the practice. Patients we spoke with told us they were treated with care, dignity, respect and understanding.

We reviewed the most recent data available for the practice on patient satisfaction. This included comments made to us from patients and information from the national GP patient survey published in January 2016.

The results from the January 2016 GP national patient survey demonstrated excellent feedback in relation to the experience of their last GP appointment, all were higher than the Clinical Commissioning Group (CCG) and national averages. For example:

- 95% said that the GP was good at giving them enough time compared to the CCG average of 92%, and national averages of 87%.
- 100% had confidence in the last GP they saw or spoke with compared to the CCG average of 97% and national averages of 95%.
- 98% said that the last GP they saw was good at listening to them compared with the CCG average of 92% and national average of 89%.

The practice did not routinely discuss the national GP survey findings with their Patient Participation Group (PPG).

The results in the national patient survey regarding nurses showed for example;

- 92% said that the nurse was good at giving them enough time compared to the CCG average of 94% and national average of 92%.
- 95% said the practice nurse was good at listening to them with compared to the CCG average of 94% and national average of 91%.

Care planning and involvement in decisions about care and treatment

Individual patient feedback we received from patients about involvement in their own care and treatment was positive, all patients felt involved in their own care and treatment.

The GP patient survey information we reviewed showed patient responses to questions about their involvement in planning and making decisions about their care and treatment with GPs in comparison to national and local CCG averages. The GP patient survey published in January 2016 showed;

- 88% said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 93% said the last GP they saw was good at explaining tests and treatments which was higher when compared with the CCG average of 90% and national averages of 86%.
- 91% said the last nurse they saw was good at involving them about decisions about their care which was higher than the CCG average of 89% and national average of 85%.
- 92% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.

Patient/carer support to cope emotionally with care and treatment

Patients gave positive accounts of when they had received support to cope with care and treatment.

The practice's computer system alerted staff if a patient was also a carer. The practice community and care co-ordinator were working towards improving the carers

Are services caring?

register, as of June 2016 there were 188 carers on the register (equal to 1.9% of the practice population). Known carers had been offered an annual health check and seasonal flu vaccination.

If a patient experienced bereavement, practice staff told us that they were supported by a GP with access and signposting to other services as necessary.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

- The practice offered extended hours evening appointments from 7.30am on a Monday, Tuesday and Wednesday and on one Saturday each month an appointment only surgery.
- Online services for ordering repeat prescriptions and appointments were available.
- Same day appointments were available for children and those with serious medical conditions.
- Telephone consultations were available with the GP and nurse.
- There were longer appointments available for patients with a learning disability.
- Emergency admissions to hospital were reviewed and patients were contacted to review their care needs if required.
- There were disabled facilities, a hearing loop and translation services available.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice provided a minor surgery clinic.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.

Access to the service

The practice was open each weekday from 8am to 6pm. Extended hours were provided from 7.30am on Monday, Tuesday and Wednesday and the practice provided an appointment only surgery held on one Saturday each month. The practice had opted out of providing cover to patients outside of normal working hours. The out-of-hours services were provided by Shropdoc which included the margins between 8am and 8.30am and 6pm and 6.30pm. The practice telephones switched to the out-of-hours service each weekday evening and during weekends and

bank holidays. During the practice open times the telephone lines and the reception desk were staffed and remained open. The practice offered pre-bookable appointments and telephone access appointments for all patients who required an urgent (same day) appointment.

Patients could book appointments in person, by telephone and on line access. The availability of appointments was a mix of book on the day or routine book ahead. We saw that the practice had availability of routine appointments with GPs and nurses within a day.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made by contacting the appropriate emergency service to meet their needs. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Results from the national GP patient survey published in January 2016 showed patient satisfaction was lower when compared to local and national averages:

- 71% of patients found it easy to contact the practice by telephone compared to the CCG average of 86% and national average of 73%.
- 89% of patients said the last appointment they made was convenient compared to the CCG average of 94% and national average of 92%.
- 53% of patients felt they did not have to wait too long to be seen compared to the CCG average of 62% and national average of 58%.
- 80% of patients described their experience of making an appointment as good compared to the CCG average of 82% and national average of 73%.

The practice had worked closely with the Good Neighbours scheme with GPs attending their regular meetings. This was a group of patients who worked on a voluntary basis to provide transport to appointments and some non-clinical support services to patients. They also fundraised for the practice and transformed the flu vaccination clinics into more of a social event. The patient participation group (PPG) was virtual and the practice had recently approached a member of the group to ascertain whether the PPG could consider meeting with the practice in the near future. (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services).

Are services responsive to people's needs?

(for example, to feedback?)

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.

Information was available to help patients understand the complaints system and the complaints process was displayed on notice boards, website and a practice leaflet.

The practice had received six complaints in the last 12 months. We tracked two complaints and saw they had been acknowledged, investigated and responded to in line

with the practice complaints policy. The practice analysed complaints for trends but found that there were none. Complaints were discussed with staff and at practice meetings.

it was clear that learning took place and when appropriate the practice issued an apology and explained how systems had been changed to limit the risk of reoccurrence. For example, the practice had received a complaint following the development of a serious side effect that can occur in patients on medicines called neuroleptics/ antipsychotics. The practice identified patients on older antipsychotic medicines and changed their medication with consultant advice; they also placed alerts on patient records for patients on this type of medicine to ensure they received the appropriate annual checks.

Are services well-led?

Good 

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

Our findings

Vision and strategy

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

- Staff knew and understood the practice values.
- The practice had a strategy and supporting business plan which reflected the changing primary care priorities and this was regularly monitored. For example, the practice had reviewed its staff skill mix in order to meet the demands on its services, had recruited an Advanced Nurse Practitioner to assist with clinical triage and had reviewed its duty doctor system to ensure continuity of care per episode of care/treatment for its patients.

Governance arrangements

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

- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous performance management and interrogation of their systems to internally audit and monitor quality and to make improvements was undertaken.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Practice specific policies were implemented, monitored and reviewed and were available to all staff. Some policies required additional detail to make them more meaningful. For example, the practice training policy did not outline the practice expectations regarding all staff training or role specific training, or how often refresher training was required. The safeguarding policy contained blank areas for the practice to enter practice specific or location specific data which had not been completed.
- The practice staff training planner, did not include information of the specialist training required for clinical staff, with clear dates noted for refresher training to enable governance and oversight. For example, it was

not clear whether all staff had received infection prevention and control training at induction or been in receipt of hand wash training or refresher training with the exception of the nursing staff. The e-learning system did highlight when staff had completed any training on line and the practice relied on staff to ensure they completed this training.

Leadership and culture

The GP partners, practice manager and patient service managers were visible in the practice and staff told us they were approachable and took the time to listen to staff.

Staff told us that they felt supported and able to make suggestions to how the practice provided services. The practice had identified staff for key leadership roles within the practice. The practice did not hold minuted regular whole staff meetings, although staff said they all met during the protected learning time dates at least three times a year for training updates.

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

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

Practice seeks and acts on feedback from its patients, the public and staff

The practice had a virtual patient participation group (PPG) who were considering whether they could meet with the practice on occasions. They worked with staff to improve services. (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services). We spoke with one member of the PPG. They informed us they felt valued by the practice team and that the practice would respond and action any reasonable suggestions made. The main priorities for joint working between the practice and PPG had been:

- Recruitment and retention of GPs

Are services well-led?

Good 

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

- Assisting the practice in its eligible population group's awareness of the flu vaccination programme.

The staff had a good insight into the broad feelings of patients about their experience of the practice. Staff told us they felt able to provide feedback and discuss any issues in relation to the practice. Staff received annual appraisals and had a personal development plan.

Continuous improvement

Staff told us that the practice supported them to develop professionally. The practice had reviewed its access and duty doctor system. The practice as a direct result had been able to open up further telephone consultation slots to the benefit of its patients.