

Trent Vale Medical Practice

Quality Report

Trent Vale Health Centre
876 London Road
Stoke on Trent
Staffordshire
ST4 5NX

Tel: 01782 746898

Website: www.trentvalemedicalpractice.co.uk

Date of inspection visit: 31/10/2016

Date of publication: 16/11/2016

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



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 Trent Vale Medical Practice on 4 May 2016. A breach of legal requirement was found and a requirement notice was issued. After the comprehensive inspection the practice sent us an action plan to say what they would do to meet

legal requirements in relation to:

- Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment

We undertook a focused inspection on 31 October 2016. We did not visit the practice but reviewed information sent to us by the provider. The inspection was to check that the practice had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Trent Vale Medical Practice on our website at www.cqc.org.uk.

Our key findings were as follows:

- The practice operated a safe, effective system for acting upon medicine safety alerts.
- The process for investigating and recording significant events was comprehensive, thorough and used regularly.
- The practice had an automated external defibrillator (AED) available if required in a serious medical emergency.

Overall the practice is rated as good overall and good in the safe domain. The change of rating in the safe domain means that the care the practice provides to patients whose circumstances make them vulnerable is now rated as outstanding. This recognises the improvements made to the quality of care provided by this service.

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:

Following our last inspection on 4 May 2016, the practice had taken action by:

- Introducing an effective system to act upon alerts about medicines that may affect safety. All previous alerts had been reviewed and appropriate action was taken.
- The practice had strengthened their process of handling significant events by including detailed investigations and reviews over time to ensure any changes made had worked. (Significant events can be described as a positive or negative occurrence that are analysed in a detailed way to learn and improve practice).
- The practice had an automated external defibrillator (AED) available in case it was required in a serious medical emergency.

Good



Trent Vale Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) inspector.

Background to Trent Vale Medical Practice

Trent Vale Medical Practice is registered with the CQC as a partnership provider.

The practice provides services via purpose built premises and at the time of our inspection 9,161 patients were registered to receive care and treatment. The partnership arrangements comprise of four partners holding a General Medical Services contract with NHS England.

The practice demographic is broadly similar to the national average although the practice has a 3% higher proportion of patients aged less than 18 years of age, when compared with the national average. The locality is one of less deprivation than the clinical commissioning group (CCG) area, although deprivation is higher than the national average. Geographically, the practice is less than one mile away from a major hospital serving the area.

The practice is open each weekday from 8am to 6pm. During these times the reception desk is staffed and remains open. The practice is contactable by telephone within core opening times with the exception of 1pm to 2pm and also a Thursday afternoon 1pm – 6pm. During lunchtimes an answer machine gives an emergency contact number to call and this is covered by a duty GP.

After 1pm on Thursday incoming telephone calls are diverted to the locality out-of-hours provider. Extended hours appointments with both GPs and nurses are offered

on Monday and Thursday until 7:45pm. The practice has opted out of providing cover to patients outside of normal working hours. These out-of-hours services are provided by Staffordshire Doctors Urgent Care Limited.

Staffing at the practice includes:

- Seven GPs (four female, three male).
- One registrar GP (currently female)
- Two practice nurses (female)
- Two healthcare assistants (female).
- A practice manager and senior receptionist lead a team of data quality facilitators, administrative and reception staff.

Why we carried out this inspection

We carried out a focussed inspection of the services under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 4 May 2016 had been made. We inspected the practice against one of the five questions we ask about services: is the service safe. This is because we found that the service was not meeting one legal requirement at the previous inspection.

How we carried out this inspection

A Care Quality Commission inspector requested information and records from the practice. We were able to perform our checks without visiting the practice.

Are services safe?

Our findings

During our inspection on 4 May 2016 we identified that the practice needed to take action in the following areas:

- The practice did not operate an effective system to act on alerts about medicines.
- We saw there was openness and reflection in the way the practice dealt with significant events. (Significant events can be described as a positive or negative occurrence that are analysed in a detailed way to learn and improve practice). Whilst the system was well used and demonstrated an embedded clear culture of openness, we saw, at times, the recorded investigation lacked detail. Another less positive area was that significant events were closed on discussion, missing the opportunity for a review to see if the changes implemented as a result had worked.
- The practice did not have an automated external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm).

During our inspection on 31 October 2016 we found:

- The practice had responded quickly to the identified issue with not receiving medicine alerts. Audits had been undertaken of previous alerts and where necessary patients had been contacted and changes made to medicines. The practice shared their actions on all alerts issued in the last two years and thorough accurate records had been kept on any action needed.
- The process for handling significant events had been strengthened by incorporating review dates on all significant events and recording investigations in a detailed analytical way. There had been 10 significant events recorded since our last inspection and all had been investigated and reviewed with further review dates planned.
- An AED had been installed at the practice shortly after our last inspection. All staff had received appropriate training, with plans for staff to receive regular updates.