

biddulphdoctors

Quality Report

Biddulph Primary Care Centre
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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 at Biddulphdoctors on 14 August 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 to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of prescribing disease modifying medicines without sight of the patient's blood results.
- 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.
- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Ensure that copies of certificates of staff qualifications are retained within the practice.
- Ensure that disease modifying medicine prescribing processes including sight of patients' blood results are documented and any risks identified are mitigated between the prescriber and rheumatology department, or hospital.

Summary of findings

- Consider improvements to the practice business continuity plan.

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 good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. 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 also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found they could make an appointment with a named GP and that 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. 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 good for the care of older people. 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. The practice responded to the needs of older people, especially for those with enhanced needs, including by offering rapid access home visits and timely telephone responses. All these patients had an alert that showed up on accessing their electronic record. The practice employed a matron who visited patients at home as well as at the practice. The practice matron worked closely with the community healthcare employed matron and case manager and together with the GPs worked closely with the district nursing team based in the practice building to offer coordinated care to patients.

Good



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. The practice had involvement with a British Lung Foundation initiative into asthma care, involving increasing use of the asthma control test. The local clinician educator for this was the practice lead nurse practitioner. The percentage of patients who had already received a care plan review in the last five months was 60% (April 2015 to August 2015). The practice employed a diabetic specialist nurse to give dedicated care to their diabetic patients and had a lead doctor with additional diabetic qualifications. We saw that 19% of patients with high blood pressure on the practice register and 81% of these patients had received a blood pressure review in which their blood pressure recording was within a set parameter within the last five months (April 2015 to August 2015).

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

Good



Summary of findings

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 high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice also provided a service for a local boarding school / organisation for children in care. We saw good examples of joint working with midwives, health visitors and school nurses. The GP child protection lead, worked closely with local health visiting team and systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect.

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 online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice had recently started electronic prescribing directly to patient's choice of pharmacy. The practice was involved in the implementation of an innovative new system of assessing low back pain, particularly stratifying the risk of developing long-term problems with the use of a computerized assessment tool. Risk stratification is the process of identifying the relative risk of patients in a population by analysing their medical history. They offered NHS health checks for people aged 40–74 and had a high rate of providing vascular risk scores whenever they could to inform patients of their medical risks and opportunities. The practice demonstrated a year on year improvement to April 2014 in the percentage of eligible patients who had taken up the offer of NHS health checks from 41% to 67%.

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 homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability and patients 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

Good



Summary of findings

people. It had told 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.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Fifty-four percent of the 71 patients experiencing poor mental health had an agreed care plan in place in the period April 2015 to August 2015. In line with QOF aspirations, the practice offered physical health checks to all patients experiencing poor mental health and checked that all appropriate care reviews had been carried out by specialist mental health care teams. 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. Staff had received training on how to care for people with mental health needs and dementia. The practice appropriately shared information on relevant A&E attendances such as patients who overdosed on medicines to all appropriate practice clinicians.

Good



Summary of findings

What people who use the service say

Results from the National GP Patient Survey July 2015 (from 123 responses which is equivalent to 0.14% of the patient list) demonstrated that the practice was performing in line with local and national averages. For example:

- 59% of respondents with a preferred GP usually get to see or speak to that GP compared with the local CCG average of 58% and national average of 60%.
- 82% of respondents say the last GP they saw or spoke to was good at treating them with care and concern compared with the local CCG average of 84% and national average of 85%.
- 89% of respondents say the last GP they saw or spoke to was good at listening to them which was the same as the local CCG and national average of 89%.

The practice scored slightly lower than average in terms of patients not being kept waiting long for their allocated appointments and patients found the receptionists helpful. For example:

- 60% of respondents usually wait 15 minutes or less after their appointment time to be seen compared with the local CCG average of 69% and national average of 65%.
- 83% of respondents find the receptionists at this surgery helpful compared with the local CCG average of 88% and national average of 87%.

However, 94% of respondents were able to get an appointment to see or speak to someone the last time they tried compared with the local CCG average of 88% and national average of 85%.

As part of our inspection process, we asked for CQC comment cards to be completed by patients prior to our inspection. We received 31 comment cards which were all positive about the standard of care received. Reception staff, nurses and GPs all received praise for their professional care and patients said they felt listened to and involved in decisions about their treatment. Four patients' comments included access to the service, for example, difficulty in gaining phone access first thing in the morning, waiting time to see a GP was 50 minutes on one occasion for a patient and another patient commented on the limited number of pre-bookable appointments. Patients informed us that they were treated with compassion and some gave examples of when the GPs and nurses went the extra mile to provide care when patients required extra support. We also spoke with two members of the recently formed PPG who told us the practice was working with them and encouraged their opinions and views.

Areas for improvement

Action the service **SHOULD** take to improve

- Ensure that copies of certificates of staff qualifications are retained within the practice.
- Ensure that disease modifying medicine prescribing processes including sight of patients' blood results are documented and any risks identified are mitigated between the prescriber and rheumatology department.
- Consider improvements to the practice continuity plan.

biddulphdoctors

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a specialist advisor and an Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to biddulphdoctors

Biddulphdoctors is situated in the area of Biddulph, Stoke On Trent, Staffordshire. It is part of the NHS North Staffordshire Clinical Commissioning Group. The practice is located in a primary care centre, a purpose built property which it shares with another practice and other community health professionals. There are 10,760 patients on the practice list. The practice has four GP partners, one female and three male, and a female salaried GP. As part of the clinical team there is a practice matron, a nurse practitioner/prescriber, a diabetic specialist nurse, two practice nurses and two healthcare support workers. The practice management and support team includes, a practice manager, office manager and reception and administration staff. The practice currently has a rotational Foundation Year (FY) 2 trainee. FY2's are qualified junior doctors who rotate around clinical specialities which include four months in a GP practice. The practice is a GP vocational training practice as well as providing FY2 training.

The practice is open Monday to Friday 8am to 12.30pm and 1pm to 6.30 pm with the exception of

Thursday when the opening hours are 8am to 1pm. When they are closed between 12.30 pm and 1.00pm for administrative purposes, telephone access is available (with the exception of Thursday's when they are open until 1pm). Patients requiring a GP outside of normal working hours are advised to contact the 111 out of hours service which includes Thursday afternoons.

The practice provides a service to three local nursing / residential care homes and for a local boarding school / organisation for children in care. It also provides a Friday morning phlebotomy (blood taking) service. The practice offered an in-house service for patients who require cryotherapy with liquid nitrogen treatment (The removal of some skin lesions, such as warts, by freezing them).

The number of this service is clearly displayed in the reception area and on the practice website and brochure. The practice has a GMS (General Medical Services) contract and also offers enhanced services for example; various immunisation and health check schemes for timely diagnosis and support for people with learning disabilities.

Why we carried out this inspection

We carried out an 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.

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out

an announced visit on 14 August 2015. We spoke with a range of staff including GPs, the practice nurses, practice manager, reception and administration staff on the day. We sought views from representatives of the patient participation group, looked at the 31 comment cards and reviewed survey information.

Are services safe?

Our findings

Safe track record

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were entered onto their report template systems and automatically treated as a significant event. The practice carried out an analysis of the significant events and this also formed part of the GPs' individual revalidation process. The practice could demonstrate its safe track record through having risk management systems in place for safeguarding, health and safety including infection control, medication management and staffing. 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.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 18 significant events that had occurred during the last 12 months and saw this system was followed appropriately. For example, a prescription was generated by the practice for a medicine which could not be prescribed in primary care. Clinicians shared this information to improve staffs knowledge and understanding and reduce the risk of reoccurrence. Significant events were discussed as a standing item on the practice meeting agenda, and during the subsequent practice meeting they reviewed actions from past significant events and complaints. All staff received copies of the minutes produced from these meetings which ensured they had awareness of any changes or improvements made as a result. Staff confirmed they could access policies, procedures or information on changes to practice derived from any learning or action points from incidents, events, compliments or complaints. All staff knew how to raise an issue for consideration at the meetings held and they felt encouraged to do so.

Staff used incident forms and these completed forms were sent to the practice manager. She showed us the system used to manage and monitor incidents. We saw records were completed in a comprehensive and timely manner.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were received by all clinical staff at the practice. Staff we spoke with were able to give examples of alerts relevant to the care they were responsible for. They also told us alerts were discussed at meetings to ensure all were aware of those relevant to the practice and where action was needed to be taken.

Reliable safety systems and processes including safeguarding

There were arrangements 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 were lead GPs for safeguarding adults and for children. The GPs attended 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.

There was a chaperone policy, which was visible on the waiting room noticeboard and in the consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All staff that provided a chaperone service had been in receipt of chaperone training. Training ensures staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Staff members undertaking chaperone duties had received a Disclosure and Barring Service (DBS) check. (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 had systems in place which allowed for the identification and follow up of children, young people and families living in disadvantaged circumstances (including looked after children, children of substance abusing parents and young carers). The GPs and nursing staff informed us that they followed up on children who persistently failed to attend appointments for childhood

Are services safe?

immunisations with follow up letters, phone calls and referrals to the health visitor. The practice electronic systems also identified older and vulnerable patients such as those living with dementia.

Medicines management

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice ensured they were prescribing in line with best practice guidelines for safe prescribing and used the computer software support with the CCG pharmacy teams to support them further. Prescription pads were securely stored and there were systems in place to monitor their use. We found that the system in place to manage some specific disease modifying medicines needed to be reviewed. Prescribers did not always have sight of the patient's actual blood test results prior to repeat prescribing as they relied on the services of the rheumatology service to inform them of any changes. Risks such as patient non-attendance at these clinics or mislaid discharge or change to dosage letters needed to be taken account of. The GPs at the practice assured us that they would consider any risks identified to ensure they are mitigated between the prescriber and rheumatology department.

Cleanliness and infection control

Appropriate standards of cleanliness and hygiene were followed. The lead practice nurse was the clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. All staff were aware of who the lead was. There was an infection control protocol in place and staff had received up to date training. The practice took part in annual audits and acted on any areas for improvement. The practice also monitored its use of antibiotics to ensure they were not overprescribing, to tackle patients antimicrobial resistance (Antibiotic resistance is when a strain of bacteria no longer responds to treatment with antibiotics). The primary care centre in which the practice was located had carried out Legionella risk assessments and regular monitoring.

Equipment

All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked and calibrated to ensure it was working properly.

Staffing and recruitment

Recruitment checks were carried out and the four files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Copies of certificates of staff qualifications were not always retained within the practice, for example the nursing staff training certificates were held by staff themselves. The practice manager assured us that this would be addressed.

Monitoring safety and responding to risk

The practice also had a variety of risk assessments in place to monitor the safety of the premises such as control of substances hazardous to health and infection control. The practice had up to date fire risk assessments and staff had attended fire drills.

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 any emergency. All staff received annual basic life support training and there were emergency medicines available as well as oxygen with adult and children's oxygen masks. The practice shared a defibrillator with a co-located practice which was readily available. There was also a first aid kit and accident book available. We found that equipment on the trolley used in the event of an emergency included the electrocardiogram (ECG) equipment. (An ECG is used to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain). In the event a patient required an ECG the emergency trolley when required may not be always be in its normal location. There was system in place to track the emergency trolleys location to ensure it was known to staff. This included a laminated sheet completed by staff detailing the room location of the ECG and emergency trolley when it was in use.

As the practice was located in a primary care centre, and the practice manager held copies of the general risk assessment which included records of regular checks of the building and environment. The practice had a business continuity plan in place for major incidents such as power failure or building damage; however the practice risk assessment embedded in the document offered greater

Are services safe?

detail. The practice acknowledged that the plan could be more detailed and had been pursuing this with the

landlords of the building since their move into the new practice premises two years earlier. The practice manager gave assurances that this would be addressed with the landlord.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with the National Institute of Health and Care Excellence (NICE) best practice guidelines and 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. For example, NICE guidance for patients with atrial fibrillation.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (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. Patients who had long term conditions were continuously followed up throughout the year to ensure they all attended health reviews. Current results were 87.9% of the total number of points available. The practice participated in a local quality scheme between January to March 2014. This practice was not an outlier for clinical targets. The practice QOF data showed 45.95% patients aged 75 or over who had a fragility fracture were treated with an appropriate bone-sparing agent when compared with the national average of 81.27%. The GP told us their data reflected the systems they had in place, patients assessed and diagnosed with osteoporosis or as requiring a bone sparing agent were placed on an appropriate bone-sparing agent, but not all patients in this age group with a fragility fracture at the practice had a scan proven osteoporosis.

Quality and Outcomes Framework data from 2013 to 2014 showed:

- Performance for diabetes assessment and care was in line with the national averages. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading was within a set parameter, was 82.27% when compared with the national average of 78.53%.
- The percentage of patients with hypertension having regular blood pressure tests was 82.18% which was comparable to the national average of 83.11%.

- Performance for mental health assessment and care was comparable to national averages. For example, the percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 94.44% when compared with the national average of 95.28%.

The practice could evidence quality improvement with two cycle clinical audits and all relevant staff were involved. The practice participated in local CCG audits such as antibiotic prescribing. Information from the practice audit of medicines used to treat pain and inflammation prescribing in Ischaemic Heart Disease (A condition that affects the supply of blood to the heart), found that all GPs were prescribing in line with guidance from the Medicines & Healthcare products Regulatory Agency (MHRA). The MHRA is an executive agency of the Department of Health in the United Kingdom which is responsible for ensuring that medicines and medical devices work and are acceptably safe.

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 clinical sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. 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 and in-house training.

Working with colleagues and other services

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care

Are services effective?

(for example, treatment is effective)

providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. Patients were referred to hospital using the 'Patient Choose and Book' system and used the two week rule for urgent referrals such as cancer. The practice had monitoring systems in place to check on the progress of any referral. The practice liaised with other healthcare professionals such as the Community Diabetic Specialist, Health Visitor, the Community Matron and the Community Mental Health Nurse. There was evidence within the practice that suggested the practice worked collaboratively with the local nursing and residential homes and provided effective communication and supported patients with compassion, dignity and respect.

Information sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. Individual clinical cases were analysed at informal meetings between clinicians. The practice in conjunction with community nurses and matrons held regular Gold Standard Framework (GSF) meetings for patients who were receiving palliative care. The practice also took part in regular multi-disciplinary meetings to discuss the needs of vulnerable patients with partner agencies such as drug and alcohol services. The practice used summary care records to ensure that important information about patients could be shared between healthcare settings. The practice planned and liaised with the out of hours provider regarding any special needs for a patient; for example regarding end of life care arrangements for patients who may require assistance over a weekend. The practice operated a system of alerts on patients' records to ensure staff were aware of any issues. For example alerts were in place if a patient was a carer.

Consent to care and treatment

Patients' consent to care and treatment was always 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. Consent forms for any surgical procedures were used and scanned in to the medical records.

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 then signposted to the relevant service. A dietician was available to refer to and smoking cessation advice was available.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 86.2%, which was higher than 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. As an example the number of patients that attended for bowel cancer screening between 2014 and 2015 was 29% of those that were offered.

Childhood immunisation rates for the vaccinations given were better than the local CCG averages. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 98.3% to 100% and five year olds from 96.7% to 100%. Flu vaccination rates for the over 65s were 73.67%, and at risk groups 59.79%. These were also slightly better than 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. The practice demonstrated a year on year improvement to April 2014 in the percentage of eligible patients who had taken up the offer of NHS health checks. Appropriate follow-up 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 people 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.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in July 2015. For example:

- 89% said the GP was good at listening to them which was the same as the local CCG and national average of 89%.
- 88% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- 82% of patients said the last GP they saw or spoke to was good at treating them with care and concern which was slightly lower than the local CCG (84%) and national average (85%).
- 79% of patients said that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care this was slightly lower than the local CCG and national average of 81%.

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 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 the results from the national GP patient survey published in July 2015 showed:

- 83% said the last nurse they saw or spoke to was good or very good at involving them about their care which was slightly lower than the local CCG and national averages of 85%.
- 84% of respondents said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient/carers 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. Written information was available for carers to ensure they understood the various avenues of support available to them. Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find or use a local support service.

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 CCG to improve outcomes for patients in the area. For example, the practice recently recruited and set up a Practice Participation Group (PPG) which had met twice and planned to carry out patient surveys and discuss proposals for improvements to the practice management team. The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system and many staff had attended equality and diversity training. To ensure staff awareness in diverse society and to be able to respond appropriately and sensitively to this diversity, such as gender, race, ethnicity, disability, religion, sexuality, class and age.

Services were planned and delivered to take into account the needs of different patient groups. For example;

- The practice demonstrated that they constantly adjusted the number of book on the day appointments according to patient demand and staff availability. This enabled flexibility based primarily on demand.
- The practice offered an in-house phlebotomy service (blood taking) daily as opposed to requesting their patients travel to other phlebotomy services not always as readily accessible to patients living locally to the practice.
- On-line booking was available for patients.
- Telephone GP and nurse consultations were available
- There were longer appointments available for people with a learning disability.
- Home visits were available for elderly patients.
- Urgent access appointments were available for children and those with serious medical conditions.
- Other reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services. For example for patients with dementia or reduced mobility patients with long term conditions, the practice matron visited patients in their own homes. The practice matron then liaised with the community matron and district nursing teams in ensuring a holistic approach to the care and support provided.
- There were disabled facilities, hearing loop and translation services available.

- The practice offered a childhood immunisation and vaccination program and worked with the health visitors to ensure attendance and follow up those who do not attend.

Access to the service

The practice was open Monday to Friday 8am to 12.30pm and 1pm to 6.30pm with the exception of Thursdays when the opening hours were 8am to 1pm. When the practice closed between 12.30pm and 1.00pm for administrative purposes, telephone access was available (with the exception of Thursday's when the lines were open until 1pm). Patients requiring a GP outside of normal working hours were advised to contact the 111 out of hours service which included Thursday afternoons.

In addition to pre-bookable appointments that could be booked in advance urgent appointments were also available. Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages. Patient's we spoke with on the day were able to get appointments when they needed them. For example:

- 94% were able to get an appointment to see or speak to someone the last time they tried compared to the local CCG average of 88% and national average, 85%.
- 96% said the last appointment they got was convenient compared to the local CCG average of 94% and national average, 92%.
- 83% described their experience of making an appointment as good compared to the local CCG average of 76% and national average, 73%.
- 70% found it easy to get through to this surgery by phone compared to the local CCG average of 73% and national average, 73%.
- 61% were satisfied with the surgery's opening hours compared to the local CCG average of 77% and national average of 75%.

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.

Are services responsive to people's needs? (for example, to feedback?)

We saw that information was available to help patients understand the complaints system for example, the practice brochure and website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice completed an annual review each year of the total number of complaints received including figures such as the number of complaint forms requested, forms received back and complaints received both verbal and

written. We looked at two complaints of the nine received in the last 12 months and found they were satisfactorily handled, dealt with in a timely way and with openness and transparency. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, concerns were raised in respect of a patient's prescription and as a consequence of the incident a fourth prescription checking process was put in place.

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 knew and understood the practice ethos and values.

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:

- 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.
- The management team had a comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit 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 prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

We saw minutes from the regular whole team, clinical and practice meetings that were held, as well as the multi-disciplinary and external meetings staff also attended. Staff told us that there was an open culture within the practice, they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. We also noted that team training events or social events took place on average every six months. Staff said they felt respected, valued and supported, particularly by the partners in the practice. 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.

Practice seeks and acts on feedback from its 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 started to gather feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which had met on two occasions to date. They planned to carry out patient surveys and submit proposals for improvements where applicable to the practice management team. The PPG hoped to recruit new members to ensure they fully represented the ethnic groups and diversity of patients registered at the practice.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. An example included when a staff member requested role specific training to improve patient care and made suggestions to streamline clinical policies into one area within the practice computer systems. The practice had listened to staff feedback and implemented these changes and enabled further training. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and driven to improve outcomes for patients in the area. The practice had provided training for Foundation Programme year two (FY2) since August, 2009 and became a training practice from August, 2015. Other examples included:

- A self-employed Diabetic Specialist Nurse had worked two sessions per week at the practice since October, 2013.
- The practice was a member of the Consortium of Research General Practices in North Staffordshire and worked in partnership with the Primary Care Research Network to carry out research.