University Medical Centre - Keele

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 at the University Medical Centre - Keele on 28 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for 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 and people experiencing poor mental health (including people with dementia).

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

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks.
- There were robust recruitment systems in place to ensure the safety of patients.
- Patients' needs were assessed and care was planned and delivered in line with current legislation.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said that overall they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- There was a transparent and inclusive culture at the practice which encouraged contributions from staff and patients in the development of the service.
- Information about services and how to complain was available and easy to understand.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe and all staff had received safeguarding training and knew how to identify patients at risk of abuse.

Are services effective?

Good

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. Patient's 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. Any further training needs had been identified and appropriate training planned to meet these needs. There was evidence that appraisals had been completed for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. The practice had a high student patient population with 1000 new students each year registering with the practice. Patients told us that the staff at the practice were experienced in dealing professionally and sympathetically for those who lived away from home. Data showed that most patients of all age groups rated the practice higher than others for several aspects of care. Patients said they were treated professionally, with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

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 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 provided a

Summary of findings

dispensary service to meet the needs of the local patient population. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and staff understood 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 and worked closely with the practice.

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. 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 older people in its population and had a range of enhanced services, for example, in dementia. It was responsive to the needs of older people and offered home visits and rapid access appointments for those with enhanced needs. It also demonstrated a proactive approach to working with other health professionals to improve outcomes for older patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice provided chronic disease management for patients with asthma, diabetes and other long term conditions. 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 patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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 who were at risk, for example children on the child who were at risk of harm. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice offered access to the hospital at home service for children who needed a medical review during out of hours periods.

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 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 reflected the needs for this population group. The practice provided a small dispensary to support the student population and for other patients who lacked transport.

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. 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. The practice did not have any patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability at the time of the inspection.

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). For 15 out of 20 patients experiencing poor mental health had received an annual physical health check at the time of the inspection. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. For example, the practice worked closely with Keele University's student support and counselling / mental health services, Community Psychiatric Nurses, Improving Access to Psychological Therapies (IAPT) and the Early Intervention Team.

Summary of findings

What people who use the service say

We reviewed 24 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that all of the patient feedback was positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were friendly and professional. They said staff treated them with dignity and respect and they felt listened to and understood. We did not receive any negative comments. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said they would recommend the practice to others.

The national patient survey 2014 and a patient satisfaction survey undertaken by the practice in 2013/2014 in conjunction with the patient participation group (PPG) also showed that patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed that the practice scored 87% by patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses, for example 93% of practice respondents said the GP was good at listening to them and gave them enough time.

University Medical Centre - Keele

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 specialist advisor and a practice manager specialist advisor.

Background to University Medical Centre - Keele

The University Medical Centre - Keele serves the whole of the Keele University Campus, Keele village and certain areas in Newcastle-under-Lyme. The practice team includes two GP partners and one salaried GP (two male and one female), two nurse practitioners, a practice manager, a dispensary manager, dispensers and administrative and reception staff.

There are 6700 patients registered with the practice. The majority of patients who use the practice are aged between 15 and 24 years of age.

The practice is open from 7.30am to 6pm Monday and Friday, Tuesday 8am - 6pm, Wednesday 7.30am – 7.30pm and Thursday 8am - 1pm.

The practice treats patients of all ages and provides a range of medical services. This includes a number of services such as specialist clinics for asthma, diabetes and chronic obstructive pulmonary disease (lung disease). It also offers child immunisations, a specialist clinic for children and pregnant women, contraception advice, travel health vaccines and a minor surgery service. There is an an on–site dispensing service at the practice.

The University Medical Centre - Keele has opted out of providing an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. The out of hours service is provided by the NHS 111 service.

The University Medical Centre - Keele has a contract to provide General Medical Services.

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. 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.

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?

Detailed findings

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 January 2015. During our visit we spoke with a range of staff which included two GP partners, the salaried GP, the practice manager, one nurse practitioner, the office manager, two receptionists, the dispensary manager, the chair of the patient participation group and spoke with five patients who used the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents.

We reviewed safety records and minutes of meetings where these were discussed for the previous 12 months. This showed that the practice had managed these consistently over time and so could show evidence of a safe track record over the period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. We saw that significant events were discussed at the weekly practice meetings and minutes were circulated to staff. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists and nursing staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us that alerts were discussed at the practice meeting when necessary to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as the safeguarding lead for vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to a child protection plan.

We saw that the practice had a chaperone policy which was visible on the waiting room noticeboard. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff were seen to follow the policy.

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

Good

Are services safe?

The nurse practitioners administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. The nurse practitioners were qualified as independent prescribers and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Discussion with the dispensing staff at the practice showed that they were aware prescriptions should be signed before being dispensed.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for patients to pick up their dispensed prescriptions at the practice and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from the practice were given all the relevant information they required.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice manager confirmed that the cleaning was carried out by a cleaning contractor. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

One of the practice nurses was the lead for infection control and all staff had received infection control training and annual updates. An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings for examination couches were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example spirometers and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each others annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice also had a health and safety policy.

The practice building was owned and maintained by Keele University. A number of risk assessments were seen

Good

Are services safe?

including fire, office, manual handling and equality. Staffing establishments were reviewed to keep patients safe and to meet their needs. Minimum staffing levels had been established and rotas were in place to maintain these levels. A lone worker policy was in place to cover occasions when staff worked on their own.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff explained how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support in September 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly to ensure it was suitable for use.

Emergency medicines were securely stored in each consulting room and all staff knew of their location. These included medicines for the treatment of cardiac arrest (heart stops beating) and anaphylaxis (severe allergic reaction). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure and access to the building. The document also contained relevant contact details for staff to refer to. We saw that in the event of a catastrophe Keele University would provide alternative accommodation for the service. We were told that all staff had a copy of the business continuity plan which was confirmed by those staff members we spoke with. Records also showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found that the GPs and nursing staff considered the implications of any new guidelines for the practice and took action to implement the changes. The staff we spoke with and the evidence we reviewed confirmed that actions taken were designed to ensure that each patient received support to achieve the best health outcome for them.

The GPs and nurses told us they led in specialist clinical areas for example diabetes, heart disease and asthma. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of various conditions. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner showed us data of the practice's performance for antibiotic prescribing, which was better than the Clinical Commissioning Group's local average. National data showed that the practice was in line for referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw evidence where the practice had referred a patient with a suspected cancer on the same day as seen by the GP and was seen in the hospital 10 days later.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us a number of clinical audits that had been undertaken in the last two years. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

We saw a completed audit on the use of aspirin where the practice was able to demonstrate the changes which had resulted since the initial audit. For example we were shown details of an audit of aspirin use for primary prevention of cardiovascular disease in type 1 and type 2 diabetic patients. All patients registered at the practice who had been prescribed aspirin for primary prevention were identified, contacted and the prescription was discussed and appropriate action taken when required. We saw that a re-audit was carried out a year later to assess the impact of the actions taken.

One of the GPs had attended a GP update course where it was highlighted that the guidance around primary prevention of cardiovascular disease in diabetic patients had changed. This led the GP to examine the way in which diabetic patients were managed at the practice. Following the audit changes to treatment or care were made and a second clinical audit was completed one year later which demonstrated that the outcomes for patients had improved. The GP had maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, all patients with diabetes had an annual medication review and the practice had met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease) management.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question

Good

Are services effective?

(for example, treatment is effective)

and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice supported approximately 35 patients at a local dementia care nursing home and worked with other health professionals to deliver a multidisciplinary approach and regular medicine reviews. One of the GP partners showed us how this approach had delivered a 23% reduction in accident and emergency (A&E) attendances at the local hospital and a 29% reduction in hospital admissions. The practice also provided a service to 13 patients in a 'step up step down' residential care home working with district nurses, community psychiatric nurses, social workers and other professionals. (Step up step down is a type of facility for patients who may be admitted from home for short term 24 hour nursing help, or may be admitted from a hospital ward for extra nursing to facilitate a more safe return home).

The practice had achieved and implemented the gold standards framework for end of life care. It had a small number of patients on a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that set key objectives to be achieved and identified training needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example safeguarding and fire safety awareness.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and travel health. Those with extended roles for example seeing patients with long term conditions such as diabetes and asthma were also able to demonstrate that they had completed appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that had not been followed up appropriately.

The practice had a very small number of patients with complex needs, for example those with end of life care needs (approximately seven per annum) or children who were at risk of harm (four at time of inspection). Multidisciplinary team meetings were held every quarter to discuss the needs of these patients. The practice was seen to liaise informally with palliative care nurses and other professionals to share the care of these patients. Due to the low numbers of patients with complex needs, no formal minutes were recorded for these meetings, however we were told that decisions about care planning were documented in the patient's care record.

The practice offered access to the hospital at home service for children who needed a medical review during out of hours periods which prevented unwanted admissions to hospital. It also offered an ante natal and post natal service to patients who were pregnant or new mothers.

The practice had recently been involved in a local charity funded project to detect early medical, social and mental health issues amongst the over 75 year old patient population with five other local practices. This had been extended to include those patients outside the criteria for a visit through this project. A GP partner told us that this was a novel and very proactive approach to care of the elderly.

Good

Are services effective?

(for example, treatment is effective)

They confirmed that the project had enabled them to identify important issues for this patient population group, for example mobility problems, falls, benefit issues, memory problems and social care issues.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice used the Choose and Book system which staff reported was easy to use and worked well. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had signed up to the electronic Summary Care Record and planned to have this fully operational during 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff who were asked were able to demonstrate a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure where applicable.

The practice had not needed to use restraint but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with one of the nurse practitioners to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a mental health condition and all of them had been offered an annual physical health check. Practice records showed 15 out of 20 had received a check up in the last 12 months. The practice had also been proactive to identify the smoking status of patients over the age of 16 and offered nurse-led smoking cessation clinics to these patients. We saw that the practice had received an award from the CCG in 2014 for their success in the number of patients who had stopped smoking in the previous 12 months, which was above average compared to neighbouring practices and national figures. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and referrals were provided for relevant patients those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was above the national and local Clinical Commissioning Group's (CCG) averages. We saw that there was a policy to

Good

Are services effective?

(for example, treatment is effective)

offer telephone reminders for patients who did not attend for cervical smears and a robust monitoring process in place with the practice auditing those patients who did not attend. We also saw that the practice had provided information about cervical screening in Chinese to assist this patient group.

The practice offered a full range of immunisations for children, travel vaccines (the practice was a registered yellow fever centre) and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with the local CCG averages and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and a patient satisfaction survey undertaken by the practice in 2013/2014 in conjunction with the patient participation group (PPG). The evidence from these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice scored 87% by patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 93% of practice respondents saying the GP was good at listening to them and 93% saying the GP gave them enough time.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 24 completed cards and all of the patient feedback was positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were friendly and professional. They said staff treated them with dignity and respect and they felt listened to and understood. We received no negative comments. We also spoke with five patients on the day of our inspection. All these patients told us they were satisfied with the care provided by the practice and said the care was good or excellent.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice reception desk was appropriately located to reduce the possibility of patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 86% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. Both these results were above average compared to the local Clinical Commissioning Group (CCG) area.

Patients we spoke with on the day of our inspection told us that their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They said they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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 area informing patients that this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, one of the patients who completed a CQC comment card said they had received treatment for a particular issue which had been very difficult and emotional. The patient told us that the GPs and nurses always dealt with them in a sensitive and respectful manner. The patients we spoke with on the

Good

Are services caring?

day of our inspection and the other comment cards we received were also consistent with this feedback. For example, three patients told us that staff responded compassionately when they needed help and provided support when required particularly as they lived far away from home.

Notices in the patient waiting room and the patient website told patients how to access a number of support groups and organisations. The practice also worked closely with Keele University and the practice website provided a link to the Student Support Department. Staff confirmed that they had a strong professional relationship with the Student Support team at the University which worked well for the benefit of the patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a large proportion (76%) of its patient population in the 15 to 24 years of age group. It also had a fluid population as most of its patients were students at the Keele University and the practice had a turnover of approximately 1000 new patients per year, including foreign students. It also provided services for families and retired staff on the University campus and older patients in the local community. We found that the GPs and other staff were knowledgeable about their patients and experienced in dealing with the range of health issues experienced by their patient population groups. We saw evidence that the practice provided a range of services to meet the needs of their patients including a sexual health service and it was registered as a designated yellow fever centre.

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example we saw that the practice provided double or triple appointments to meet patients' needs and early and late appointments one day per week. We were told by staff we spoke with that due to the location of the practice, no homeless people or travellers had accessed the service.

The practice worked closely with Keele University's student support and counselling / mental health services to provide a service to patients with mental health issues. The practice also had Community Psychiatric Nurse (CPN) and Improving Access to Psychological Therapies (IAPT) clinics at the practice three times per week. The GPs at the practice referred patients with mental health needs to these clinics which offered improved access to mental health services. The practice also had good access to the Early Intervention Team who provided expertise in relation to managing and supporting psychotic illness in the younger population.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw evidence where these had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. One example we saw was the practice had provided a full sexual health and contraceptive service to their predominantly student patient population for many years. The practice were in discussions with the Public Health department about the future delivery of the service.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example the practice had historically had restricted parking facilities for patients and patients had raised this as an issue. The practice and the PPG had worked together in negotiating with Keele University and successfully doubled the parking area to improve access for all patients, but particularly for the older patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example patients with mental health needs such as dementia. We saw that the practice had 39 patients with dementia and four received support from the Integrated Local Care Team and the Memory Clinic.

The practice had access to online and telephone translation services and we saw that contact details for the service were available in each consultation room. The practice had also developed a new patient satisfaction questionnaire in Chinese to support this patient population group and receive feedback from them about the service provided.

The practice provided equality and diversity training for staff. Staff we spoke with confirmed that they had completed equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team meetings.

The premises and services had been adapted to meet the needs of patients with disabilities and was accessible for wheelchair users and parents with pushchairs or prams. A car parking space was available reserved for patients who displayed a disabled badge.

The practice was situated on the ground and first floors of the building with most patient facilities available on the first floor. We saw that a consulting room was available on the ground floor to enable easy access for those patients with mobility issues.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments were available from 7.30am to 6pm on Mondays, 8am to 6pm on Tuesdays, 7.30am to 7.30pm on Wednesdays, 8am to 1pm on Thursdays and 7.45am to 6pm on Fridays.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. Longer appointments were also available for patients who needed them and for patients with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one and to two local care homes, one of which received a twice weekly ward round.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment when experiencing a mental health crisis and had contacted the practice and seen by a GP within two hours.

The practice's extended opening hours on Wednesday each week from 7.30am to 7.30pm was particularly useful to patients with work or study commitments. This was confirmed by two feedback comments received from patients who also told us that they found the online booking system and telephone consultations for patients helpful.

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, the practice manager, who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system which was included in the complaints leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found these had been handled satisfactorily and dealt with in a timely way. We found that there was an openness and transparency by staff in the practice when dealing with complaints.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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

We saw that the practice had a mission statement and a copy of this had been placed on the notice board in the reception area for the benefit of patients.

All of the practice staff demonstrated their commitment to continue to deliver high quality care and promote good outcomes for patients. We saw that the aims and objectives of the practice included: to ensure good access to the most appropriate healthcare professional, to meet the highest standards of healthcare provision and to treat all patients with dignity and respect irrespective of their ethnic origin, religious belief, personal attributes or nature of their health problem

We spoke with nine members of staff and they all knew and understood the business priorities and the practice's aims and objectives and knew what their responsibilities were in relation to these. We looked at minutes of the quarterly staff meetings held at the practice and saw that staff had discussed the future developments of the service.

The GPs and the practice manager told us that all staff were aware of the business plan for the practice which identified the need for a more modern building to meet patient's needs, to increase access for patients, to improve services for patients and to try to maintain services valued by the patients such as contraception and minor injuries. We saw minutes of meetings with the Clinical Commissioning Group (CCG) where some of these areas had been raised and seen as on-going discussions.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared computer network within the practice. We saw that there were also hard copies of all these policies and procedures in reception. We looked at eight of these policies and procedures including safeguarding, whistleblowing, equality and diversity and bullying and harassment.

We found that there were named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GPs was the lead for safeguarding.

We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed that for all relevant services it was performing above or in line with national standards. We saw that QOF data was regularly discussed at weekly meetings and action taken to maintain or improve outcomes.

The practice had completed a number of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we were shown details of an audit of aspirin use for primary prevention of cardiovascular disease in type 1 and type 2 diabetic patients. All patients registered at the practice who had been prescribed aspirin for primary prevention were identified, contacted and the prescription was discussed and appropriate action taken when required. We saw that a re-audit was carried out a year later to assess the impact of the actions taken. This demonstrated a proactive approach in monitoring the quality of the service provided to these patients. Records showed that the audits delivered benefits such as better patient treatment and evidence based patient treatment.

The practice had arrangements for identifying, recording and managing risks. We saw evidence where risk assessments had been carried out which identified key risks and action plans produced and implemented. These included fire, office, manual handling and lone worker.

The practice held regular governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed and actions taken to address any required improvements.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that minutes from team meetings were emailed to all staff to ensure everyone was kept up to date with current issues.

Are services well-led?

Good

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy and bullying and harassment which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey carried out in November 2014 and saw that patient feedback was overall, extremely positive. We saw from the survey summary that patients had identified the need for additional opening times, however some of the requested times were when the surgery was already open (early and late surgeries and lunchtimes). We also saw that the practice had an ongoing issue with patients not registering for online services. The practice and the patient participation group (PPG) were seen to be working consistently to encourage more patients to take advantage of this service.

The practice had an active PPG which included representatives from various population groups. For example, a representative from the Student Support Group at Keele University joined the group to represent the students and other representatives included an ex-student of the University, a former lecturer at the University and a retired member of the University staff.

We saw that the Chair of the PPG had been instrumental in working with the University to discuss the problems that patients had when parking on the Health Centre car park. As a result of this additional staff parking facilities were made available which increased the number of parking spaces for patient access. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

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

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included details of key objectives to be achieved and training needs agreed. Staff told us that the practice was very supportive of training and were able to access a range of training if required.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We saw an example of this where the practice had taken action in response to a prescription error to reduce the possibility of it happening again in the future.