Glebedale Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 1 December 2014 as part of our new comprehensive inspection programme.

The overall rating for this practice is good. We found the practice to be good in all areas. We found the practice provided good care to all of their population groups including older people, patients 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 dementia.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- People's needs were assessed and care was planned and delivered in line with current legislation.
- Patients were generally satisfied with how they were treated and felt that staff treated them with compassion, dignity and respect.
- The practice had a well-established and well trained team who had expertise and experience in a wide range of health conditions.
- There was a transparent and inclusive culture at the practice which encouraged contributions from staff and patients in the development of the service.

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

- Review the system for reporting, recording and monitoring significant events to ensure that actions identified for learning or improvement, as a result of the significant event, are completed.
- Ensure that all nursing staff receive the appropriate level of training around safeguarding children in line with best practice recommendations

Summary of findings

- Review the practice's safeguarding policy to ensure it is aligned with the Inter-agency Adult Protection Procedures as developed by the local Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership.
- Review how prescriptions are managed, stored and disposed of, in conjunction with national best practice guidelines.
- Ensure all areas of risk in relation to health and safety are assessed and monitored.

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. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were improving and a number were above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. People'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 and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked well within multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated 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. 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 Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said that overall, they found it easy to make an appointment with a named GP, and that there was continuity of care, with most 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 with staff and other stakeholders took place.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff understood 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 upon. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 had improved for conditions commonly found in older people such as diabetes. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care.

It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

There was a new initiative to support patients with dementia and their carers in the practice. A dementia specialist advisor from the Approach organisation, (a charity which supports older people with dementia or mental health needs), provided a regular clinic for patients with dementia and their carers in the practice.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All patients with a high level of need 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. All patients with a long term condition had a care plan and there was a robust recall system in place.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Appointments were available around school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and district nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Summary of findings

We saw that the practice was proactive in promoting the services at the practice through social media websites in order to reach the younger element of the population.

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 appointments, Saturday morning appointments and repeat prescription services, as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It confirmed that vulnerable patients were informed 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.

We saw that there was an interpreter service available to patients with a hearing impairment which the practice accessed for them through the DeafLinks organisation. The patients who were registered with sight problems had an alert on their patient record so that the GP or nurse knew to collect the patient from the waiting room.

People experiencing poor mental health (including people with dementia)

Good

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

Summary of findings

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.

There was a new initiative to support patients with dementia and their carers in the practice. A dementia specialist advisor from the Approach organisation, (a charity which supports older people with dementia or mental health needs), provided a regular clinic for patients with dementia and their carers in the practice.

Summary of findings

What people who use the service say

We spoke with 15 patients on the day of our inspection and most were very complimentary about the care and treatment they received. We reviewed the 23 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 almost all comments were very positive. Patients told us that all the staff, including the receptionists were always polite and helpful. They said that staff were respectful and treated them in a caring manner. They said the nurses and doctors listened to them and they did not feel rushed. They confirmed that they were involved in decisions about their care.

Patients told us that the practice was always clean and tidy. Three patients told us that they sometimes had problems getting an appointment, however they felt that the system was improving.

The results from the National Patient Survey 2013 showed that 82% of patients felt that their overall experience of the practice was good and 68% of patients would recommend the practice to someone new to the area. We found that there had been significant improvements in the practice since this survey was carried out. The practice, in conjunction with the patient participation group had carried out a survey in February 2014. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. Analysis of the survey showed that 91% of patients rated their level of satisfaction with the services at the practice from satisfactory through to excellent. We saw that there were some areas for improvement identified from the survey and an action plan had been put in place to address these.

Areas for improvement

Action the service SHOULD take to improve

- The system for reporting, recording and monitoring significant events should be reviewed to ensure that actions identified for learning or improvement, as a result of the significant event, are completed.
- Ensure that all nursing staff at the practice completes the relevant level of training for safeguarding children in line with best practice recommendations.
- Review the practice's safeguarding policy to ensure it is aligned with the Inter-agency Adult Protection Procedures as developed by the local Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership.
- Carry out a review of how prescriptions are managed, stored and disposed of, in conjunction with national best practice guidelines.
- Ensure all areas of risk in relation to health and safety are assessed and monitored.

Glebedale Medical Practice

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, a second CQC inspector, a practice manager specialist advisor and an Expert by Experience who had personal experience of using primary medical services.

Background to Glebedale Medical Practice

Glebedale Medical Practice is located in a purpose built primary care medical centre. It is situated in Fenton, Stoke-on-Trent and serves the local population by providing general practitioner services.

The practice has three permanent GPs (two male and one female), one nurse practitioner, two practice nurses, a practice manager, a data quality manager, a senior receptionist, a secretary and six receptionists. There are 7358 patients registered with the practice. The practice is open from 8am to 6pm, Monday, Tuesday, Wednesday and Friday and Thursday 8am to 1pm. The practice also provides a Saturday morning surgery from 8.30am to 12.15pm.

The practice has been through significant change. In January 2011, the practice took on 3000 additional patients due to the immediate closure of another practice. As a result, the management and impact of such a high number of additional patients at once was a significant factor that led to the practice having a number of performance issues in 2012. The practice has developed robust action plans to maintain continuous improvement in the service over the last two years. This shows evidence of a consistent and proactive approach by the senior management team to an ongoing commitment to improve outcomes for patients.

The practice treats patients of all ages and provides a range of medical services. Glebedale Medical Practice has a large percentage of children in its practice population, 20% aged 14 years and under.

The practice provides a number of services for example reviews for asthma, diabetes and chronic obstructive pulmonary disease (COPD). It also offers child immunisations, contraception advice and travel health vaccines.

Glebedale Medical Practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

This provider had not been inspected before and that was why we included them.

Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. These 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 carrying out our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 1 December 2014. During our visit we spoke with a range of staff, three GPs, one nurse practitioner, one practice nurse, the practice manager, the reception manager, a receptionist and the data quality manager. We also spoke with 15 patients who used the service and carers and/or family members. We reviewed 23 comment cards where patients and members of the public shared their views and experiences of 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 and near misses. One member of staff gave us an example of a recent incident of a delay in following up a patient's test result which they had raised through this process.

We reviewed safety records, incident reports and minutes of meetings over a 12 month period which showed that safety incidents were discussed regularly. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the year.

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 weekly practice meetings and effective action plans were put in place when required. The lead GP confirmed that the significant events were also reviewed annually. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. However, there was insufficient evidence to demonstrate that actions were completed as a result of the significant event.

Staff used an incident reporting file to record all incidents which were then sent to the practice manager. We were shown the system used by the practice manager to manage and monitor these incidents. We saw records which showed that these were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example in relation to a recent computer system failure.

National patient safety alerts were disseminated by the data quality 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 told us alerts were discussed at management and clinical meetings and recorded to ensure all staff were aware of those 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 specific training in safeguarding children and vulnerable adults. We saw that practice nurses had received level one training in safeguarding children. Best practice guidelines recommend all nursing staff have level two training in this area. The practice manager confirmed that this would be completed as soon as possible. We asked members of medical, nursing and administrative staff about their most recent safeguarding training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

The practice had a lead GP for safeguarding vulnerable adults and children. We saw that they had received advanced level three training in safeguarding children and training in vulnerable adults. We found that they could demonstrate how this training had supported them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. We saw that the practice had a safeguarding policy which included details of how the practice should notify the Care Quality Commission of any suspicion, concern or allegation of abuse without delay. However there was no reference in the policy to the local Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership or evidence of how the policy was aligned to the Inter-agency Adult Protection Procedures.

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 child protection plans and carers.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. All nursing staff and receptionists had carried out training to be a chaperone. All staff clearly understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Good

Are services safe?

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 followed the policy and could explain the process for maintaining medicines at the required temperatures.

Processes were in place to check medicines were within their expiry date and suitable for use. All of the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. We checked to see if any medicine management audits had been carried out and discussed this with the practice nurse. They confirmed that they had not as yet completed them, however they felt this would be beneficial particularly in relation to identifying any recurrent themes.

We saw evidence of practice meetings which showed that action had been taken in response to a review of prescribing data. For example, the pattern of hypnotic prescribing within the practice. We found that the practice had continued to improve in this area and at the time of the inspection were well within the required range as set by the Clinical Commissioning Group (CCG). The Clinical Commissioning Group monitors the performance of each general practice within its local area.

The nurses 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. A member of the nursing staff was qualified as an independent prescriber. They told us that they received regular supervision and support in their role from the on call GP and had 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. We found that blank prescription forms were kept securely at all times. However the system for managing, storing and disposing of unused prescriptions needed to be more robust and in line with national best practice guidelines.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training with the CCG lead for infection prevention and control to enable them to provide advice on the practice's infection control policy. All staff received induction training about infection control specific to their role and received annual updates. We saw a completed infection prevention and control audit had been completed by Stoke on Trent and Staffordshire Partnership Trust in March 2014 at the practice. We saw that an action plan had been developed to address any areas for improvement and the practice was in the process of completing this.

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 were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. For example when dealing with the disposal of sharps (needles) safely.

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.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

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, weighing scales and nebulisers.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for all new employees. 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. The practice manager confirmed that all other employee records were being reviewed and information would be obtained retrospectively where possible. Specifically DBS checks would be completed for all staff who had been identified to carry out chaperone duties.

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 that there was a rota system in place for all the different staffing groups to ensure that there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's 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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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, such as medicines management and staffing. We saw records of reviews of staffing levels and the skill mix of staff to ensure that patients received safe care and treatment at all times, particularly in times of higher demand such as winter periods. Identified risks were included on a risk assessment file. Each risk was assessed and rated and control measures identified. However more evidence was required to demonstrate that all areas of health and safety were assessed and monitored. For example, building checks and control of substances hazardous to health (COSHH).

We saw that risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the staff.

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 we saw evidence of how staff had recently responded to a medical emergency when a child had a serious reaction following a childhood vaccine. Staff were also able to give examples of 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. 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). Staff we spoke with knew where to access the emergency equipment if required and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylactic shock (allergic reaction) and hypoglycaemia (low blood sugar). 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 could impact on the daily operation of the practice. Risks identified included a loss of the computer or telephone systems, loss of electricity or gas. We saw that the document identified the steps that must be taken to reduce or manage the risk. The document also contained relevant contact details for staff to refer to, for example suppliers of essential supplies.

Good

Are services safe?

We saw that the practice had carried out a fire risk assessment which included actions required to maintain fire safety. Records 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 told us that the data quality manager provided them with up to date guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

The senior GP partner and practice manager showed us data produced by the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing. We saw that this was comparable to similar practices and improving. We saw there had been concentrated work carried out to improve the prescribing of appropriate antibiotics over the last nine months which had led to this position.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. We saw that this process needed to be more formalised to ensure that patients were reviewed by their GP following discharge at the most appropriate time according to their need. The practice was aware of this and were developing this support.

All GPs we spoke with used national standards for the referral of patients with suspected cancers to be referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. The two week cancer referral process was seen to be managed by one member of staff who monitored the process of referral. The paperwork for each patient was held until there was evidence on the hospital computer system that a definite appointment had been given to the patient. This showed that the process was actively managed. The staff member responsible for this confirmed that all requests for patients to have an appointment in two weeks, had been met.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and ethnicity was not taken into account in this decision-making.

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 information staff collected was then collated by the practice manager and partners to support the practice to carry out clinical audits.

The practice showed us eight clinical audits that had been undertaken since January 2014. We looked at two of these in detail and found that the practice was able to demonstrate the positive changes and outcomes resulting since the initial audit. For example one audit was carried out to monitor the prevalence of chronic obstructive pulmonary disease (COPD) in patients at the practice. The completed audit and follow up audit identified the numbers of those with COPD. It also demonstrated, that as a result of actions taken by the practice, fewer patients were treated at the hospital because of exacerbation (an increase in severity) of their condition. Another audit had been completed in relation to improving outcomes for patients with diabetes. We saw that one of the changes proposed as a result of this audit was for further training needs to be identified and courses about diabetes to be undertaken by the clinicians at the practice.

We saw that the practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to

Good

Are services effective?

(for example, treatment is effective)

monitor outcomes for patients. The QOF is a national performance measurement tool. For example, this practice had previously had negative indicators in a number of their QOF (or other national) clinical targets in June 2013. Due to the commitment and actions of the partners, management and staff in the practice, we saw that performance against indicators had significantly improved in 2014.

The team was making use of clinical audit tools, clinical supervision and mentoring, and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement and the associated learning from these.

The practice had achieved and implemented the gold standards framework (GSF) for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The GSF is a practice based system to improve the quality of palliative care in the community so that patients receive end of life care that ensures their dignity and is in line with their wishes.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had most outcomes that were comparable to other services in the area. Any areas that required further attention was in the process of being addressed and action plans were seen to support this.

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 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example one member of staff was in the process of completing a nursing degree which was supported by the practice.

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 and cervical cytology (examination of tissue cells from the body). We were also shown evidence of other appropriate training that had been completed by the nurses, for example asthma and diabetes to support patients with these long term conditions.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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. Staff who had specific responsibilities for dealing with this information told us that changes had been made to strengthen the process and provided more continuity. They told us that each letter was scanned and allocated to the relevant GP who saw the communication and results and took the required action. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every six to eight weeks to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by a variety of professionals including palliative care nurses, a community matron and a coronary care nurse specialist. Decisions about care planning were documented in a shared care record. Staff told us that these were useful as a means of sharing important information and to ensure that complex patients received joined up care and treatment.

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

Good

Are services effective?

(for example, treatment is effective)

system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

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 we saw that it scanned paper communications, such as those from hospital which were saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. We saw that clinical staff had completed relevant training and those we spoke with understood the key parts of the legislation and were able to describe how they implemented it for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

We found that there were mechanisms to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population. This information was used to help focus health promotion activity at the practice. The practice manager informed us that the practice was working closely with the CCG locality lead managers to develop a pack for patients to store care plans, management plans and other key health information in one place. This pack would be useful to support patients when attending hospital appointments for example.

It was practice policy to offer a health check with the practice nurse 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 clinicians 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 also offered NHS health checks to all its patients aged 40-75. Practice data showed that the practice were the highest achieving practice across the Clinical Commissioning Group for the number of completed health checks in 2013 to 2014.

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 learning disability who were offered a dual clinic for their annual physical health check, both with the nurse and then with the GP. Records seen showed that the practice was above average for the number of patients with a learning disability who had received a check up in the last year. We saw that there was a robust recall system which had been put in place in the last 12 months.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all childhood immunisations was generally in line with the required targets for the CCG, 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 and a survey of patients undertaken by the practice in conjunction with the patient participation group (PPG) in February 2014. The evidence from these sources showed patients were generally satisfied with how they were treated and that they were treated with compassion, dignity and respect.

Feedback from patients in the national patient survey carried out in 2013 showed that the practice was above average in some areas and needed to make improvements in others. For example 72% of practice respondents said the GP was good at listening to them (slightly below average) and 84% said the nurse gave them enough time (above average). We saw that the practice was aware of the areas for improvement and had implemented an action plan to address these which had begun to have a positive impact. We saw data from the practice's patient satisfaction survey dated February 2014 showed that 91% of respondents rated their level of satisfaction with the services at the practice from satisfactory through to excellent.

We were offered the opportunity to look at the 360 degree feedback and appraisal information in relation to two GPs at the practice in 2014. This information demonstrated that patients valued the GPs concerned, felt listened to, were involved in decisions about their care and felt supported.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards and all the feedback from patients was positive about the service experienced. Patients said that staff were helpful, kind and caring. Patients told us that they felt the practice provided a good service and two patients said that the service had improved over the last 12 months. They said staff treated them with dignity and respect and felt GPs and nurses knew what they were doing. We saw there were positive comments made about individual clinicians that patients felt they wished to highlight. We also spoke with 15 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 and 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. Three patients we spoke with told us that staff were always discreet and maintained any confidential information about them. We saw this system in operation during our inspection. We saw a poster in reception informing patients that a 'confidentiality' room was available for them if they needed to speak to a member of staff privately.

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 they would investigate this and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. This was also included on the practice website. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

We checked to see how patients felt about their involvement in planning and making decisions about their care and treatment. We saw a mixed response. For example, data from the 2013 national patient survey showed 82% of practice respondents said that the nurse involved them in care decisions (above the CCG regional average) and 71% felt the GP was good at explaining treatment and results (below the CCG regional average). These results were based on a total of 111 responses which equated to 1.5% of the total practice population.

All of the patients we spoke with on the day of our inspection told us that the GPs and nurses discussed their health issues with them and they felt involved in decision making about the care and treatment they received. They

Good

Are services caring?

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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

We saw that older patients who had been identified as at risk of hospital admission and patients with a long term condition were involved in the development of their own care plan and invited for regular health reviews.

Staff told us that translation services were available for patients who did not have English as a first language. We saw details on the website informing patients that this service was available. This ensured that all patients could understand and be involved in decisions about their care and treatment.

Patient/carer support to cope emotionally with care and treatment

Four of the patients we spoke with on the day of our inspection and comments seen in the CQC comment cards we received confirmed that patients felt staff responded compassionately when they needed help and provided support when required. Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations.

Information from the CCG identified that there were high numbers of young, unpaid carers in Stoke-on-Trent. We saw that the practice was proactive in the support of carers and had begun to develop strong links with the local carer's organisation to improve support and services for carers, particularly young carers. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice's computer system alerted GPs if a patient was a carer.

The practice manager told us about an initiative to support patients with dementia and their carers in the practice. A dementia specialist advisor from the Approach organisation, (a charity which supports older people with dementia or mental health needs), provided a regular clinic for patients with dementia and their carers in the practice. The practice manager informed us that all staff were booked to carry out training with Approach to become a 'dementia friend' and to improve support for patients with dementia and their carers.

We spoke with a patient who told us that the GP and other staff at the practice had been extremely supportive following a family bereavement. Other patients confirmed that they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people'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.

The NHS 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 minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example in relation to patients with dementia.

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 set up a Saturday morning clinic each week as a direct result of patient feedback.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, staff told us about services they provided for patients with a learning disability and homeless people. They were also proactive in working with carers and had developed links with the North Staffordshire Carer's Association to improve services for carers.

The practice website offered a facility for patients who first language was not English, to translate information into different languages. The practice also provided an interpreter service available through Language Line and one of the GPs spoke four different languages. There was an interpreter service available to patients which the practice accessed for them through the DeafLinks organisation. The patients who were registered with sight problems had an alert on their patient record so that the GP or nurse knew to collect the patient from the waiting room.

The practice was situated on the first and second floors of the building with all services for patients on the ground floor. The practice had sufficient space to enable turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

We saw that the practice supported patients who may live in vulnerable circumstances, such as those who were homeless. Staff told us that people with "no fixed abode" were signposted to use a service commissioned by the CCG in order to register for NHS services.

Access to the service

Appointments were available from 8:00 am to 6:00 pm on Monday, Tuesday, Wednesday and Friday, and from 8:00 am to 1:00 pm on Thursday. The practice was also open on Saturday mornings each week from 8:30 am to 12:15 pm. We saw that there had been a number of audits in relation to the appointment system to test its effectiveness and there was ongoing monitoring in place.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements 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.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to the local care home by one of the practice nurses routinely. The practice was in the process of working with the care home staff to develop a more formal arrangement for GPs to review the patients at the home each week.

Patients were generally satisfied with the appointments system. Patient feedback in the annual survey and patients we spoke with on the day of the inspection said that they

Good

Are services responsive to people's needs?

(for example, to feedback?)

could see a doctor on the same day if they needed to. They could see another doctor if there was a wait to see the doctor of their choice. Two other patients told us that they had a problem getting a same day appointment.

The practice's extended opening hours on a Saturday was particularly useful to patients with work commitments. This was confirmed by patients we spoke with from the working age population. The practice had an online booking system which was easy to use and they provided text message reminders to patients for their appointments.

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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. For example, details about how to make a complaint were on the practice website. We did not see any information on how to make a complaint in the waiting area of the practice for patients. Patients were provided with a complaints leaflet from reception on request. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One of the patients we spoke with had made a complaint about the practice a few months previously. They told us that the practice manager had listened to their issue and resolved the problem well.

We looked at seven complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way. The practice reviewed complaints annually to detect themes or trends. We looked at the summary report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. We found evidence of shared learning from complaints with staff and other stakeholders such as the midwives located in the building. Minutes seen of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

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 strategy and a mission statement to 'offer the highest standard of health care and advice to our patients, with the resources available to us'. We found details of the vision and practice objectives were part of the practice's strategy and a three year business plan which clearly set out the key priorities and deliverables for the practice each year. We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in individual information files for them. We looked at six of these policies and procedures and saw that they were regularly reviewed and updated. Staff told us that they had read those that were appropriate for them and understood them.

There was a clear leadership structure with 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 a variety of tools to measure its performance which included the Quality and Improvement Framework (QIF), the Quality Outcomes Framework (QOF), the Primary Care Quality Assurance toolkit, the Clinical Commissioning Group 360 degree report and internal clinical audits. We looked at some of the data for this practice which showed that it was improving its performance in line with national and local standards across the key areas. For example, this practice had previously been an outlier (a negative indicator) in nine of the Primary Care Quality Assurance Framework in June 2013. Due to the commitment and actions of the partners, management and staff in the practice, this had been reduced to three in September 2014.

We saw that performance data was regularly discussed at weekly practice meetings and action plans were produced to maintain or improve outcomes. We found there was a culture of transparency at the practice and a constant review and audit of working processes and change being undertaken to ensure the most effective and efficient working.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. For example, reception staff met every two weeks and clinician meetings took place weekly. We saw that the GPs and the practice manager also had weekly management meetings. Staff told us that information from the management meetings were cascaded to them. Staff confirmed that there was an open culture within the practice and that they had the opportunity to raise issues at team meetings. The lead GP confirmed that there was a 'no blame' culture in the practice and staff were encouraged to work to their strengths and support each other.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example a recruitment policy and an induction policy 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. The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG met every quarter and carried out annual patient satisfaction surveys in conjunction with the practice.

We looked at the results of the annual patient survey carried out in February 2014 and we saw that 91% of patients rated their level of satisfaction with the services received from the practice from satisfactory through to excellent. The survey showed that some patients had difficultly accessing urgent, same day appointments and we saw an action plan which had been put in place to address this issue. One of the actions that had been carried out was the introduction of a Saturday morning clinic and an increase in the availability of online appointments. The results and actions agreed from the survey was available on the practice website.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us that the

Are services well-led?

Good

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

atmosphere at the practice had improved over the last year and they were working well as a team. They confirmed that it had been a difficult year and although there had been many changes, they could see the benefits of the changes for them and for patients. Staff told us that they supported each other and were able to speak with their line manager, practice manager and GPs at any time. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they each had a specific area of responsibility and then had the lead for developing a protocol for that area. For example, one member of staff was developing a training manual for the practice. Staff told us this helped them to feel involved and engaged in the practice to continue to improve outcomes for both staff and patients.

Management lead through learning and improvement

The practice had a new management team which we found had had to manage a significant change programme over the last 18 months to improve services and outcomes for patients and to provide direction, leadership and support for staff. According to staff and records seen, the pace and level of change to achieve these outcomes had been extremely challenging. The results seen so far were positive and we found the practice was on a journey of continuous improvement. We were told by the practice manager and senior GP partner that the Clinical Commissioning Group (CCG) had been extremely supportive to the practice and the GPs, practice manager and other staff had embraced the learning from this support.

However the commitment from all staff at the practice to maintain the level of change required was contributory to this progress and to be commended. At the beginning of January 2011, the practice had 'stepped up' to take on 3000 additional patients due to the immediate closure of another practice. The management and impact of such a high number of additional patients at once, was a significant factor that had led to the practice having nine negative indicators for performance in 2012. This position had improved over the last two years, and in September 2014 this had reduced to three below target indicators. We saw that, in addition to this, the practice had achieved the highest score across the CCG for NHS Health checks for relevant patients in 2013 to 2014. This was evidence of a consistent and proactive approach by the senior management team to an ongoing commitment to improving outcomes for patients.

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 appraisals had been completed with detailed objectives and identified training needs for each member of staff. Staff told us that the practice was very supportive of training appropriate to their roles. We saw that there was a culture of learning, planning and change within the practice. Positive patient outcomes were the driver for change and staff worked hard to embrace the changes needed and implemented them.

The practice had plans to become a training practice for qualified doctors to become GPs. One of the GPs at the practice was trained as a GP trainer and worked one session a week at Keele University in a research role attached to the medical school.