Penkridge 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?	Requires improvement
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 carried out an announced comprehensive inspection at Penkridge Medical Practice on 7 June 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses.
- Risks to patients were assessed but not always effectively managed.
- Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance.
- Staff had received training appropriate to their roles to provide them with the skills, knowledge and experience to deliver effective care and treatment. Their career aspirations were well supported.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about how to complain was available but not readily accessible. The practice responded quickly to issues raised.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had an active patient participation group and had implemented suggestions for improvements and had made changes to the way it delivered services as a consequence of feedback.
- Access for patients had improved through the implementation of a telephone triage system.

Summary of findings

Patients requiring a same day appointment were telephoned by a GP. The GP had the options to suggest an appointment slot, issue a prescription or offer a same day appointment.

- The practice was involved in research and had worked with the Clinical Research Network in delivering high quality research opportunities to patients.

We saw one area of area of outstanding practice:

- There was a special focus on the needs of vulnerable adults. The practice was an official foodbank agency voucher provider for emergency food for local people in crisis. Staff were proud of the practices links with the food bank run by a church in Hendesford. Staff had contributed to provide a hamper of gifts for two families in need during the festive period.

The areas where the provider must make improvement are:

- Ensure recruitment checks for staff meet legislative requirements.
- Ensure there is a system in place for uniquely coding patients who were vulnerable adults.

The provider should:

- Develop the significant incident reporting process and ensure all incidents are shared, recorded and effectively audited to maximise learning and help prevent reoccurrence.
- Implement a system to track blank prescriptions held at the practice that monitors their use.
- Consider making the information about the practice's complaints procedure more accessible to patients and ensure all complaints received are effectively recorded to monitor trends.
- Ensure all staff receive fire safety training.
- Ensure all complaints are recorded to help identify any trends in complaints to improve the quality of the service provided.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- There was a system in place for reporting and recording significant events however, these were not effectively shared and audited to maximise learning and help prevent reoccurrence.
- The practice had processes and practices in place to keep patients safe and safeguarded from abuse.
- The practice had well maintained facilities and equipment.
- Infection control audits were carried out annually and an action plan was produced and reviewed.
- Risks to patients were assessed and managed.
- Fire drills were carried out annually.
- There was no system to track blank prescriptions held at the practice.
- Expiry dates of controlled drugs held at the practice were not being effectively monitored.
- Not all recruitment checks had been robustly carried out on staff that worked at the practice.
- There was good liaison with local pharmacies to ensure patients got their medicines as prescribed and safely.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above local and national averages. The practice achieved 99% of the total number of points available in 2014/15.
- Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance.
- Clinical audits were completed and repeated cycles demonstrated quality improvement.
- Staff had dedicated time for training and had the skills, knowledge and experience to deliver effective care and treatment. Their career aspirations were well supported.
- There was evidence of staff appraisals.
- Staff had regular meetings with a range of other health care professionals to discuss, understand and meet the complexity of patients' needs.

Summary of findings

- The practice provided opportunities for medical students to train. Two of the partners were training programme directors and had made enquiries to train physician assistants.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than local and national averages for most aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand.
- Staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice was an official foodbank agency voucher provider for emergency food for local people in crisis. Staff at the practice had contributed to provide a hamper of gifts for a selection of families in need during the festive period.
- The practice had a carers' register to raise staff awareness of patients that were also carers. The practice acknowledged the need to increase the size of the register to pro-actively identify carers and what support they were providing.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Priority was given to patients under the age of five, over the age of 80 and those identified on a 'gold star' board that provided staff with instant access to valuable information about patients with complex needs when prioritising appointments.
- There was an effective system in place to triage home visits and same day appointments so that patients saw the appropriate clinician at the right time.
- Patients over the age of 75 had a named GP for continuity of care.
- Patients said they could get an urgent appointment the same day. Same day appointments were available for young children and patients with serious medical conditions.
- Patients had access to a multi-disciplinary team during extended hours, for example a GP, nurse and pharmacist.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about how to complain was available but not readily accessible. The practice responded quickly to issues raised.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG).

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Most staff were clear about the vision and values and their responsibilities in relation to it.
- There was an established staff team with a clear leadership structure and defined roles. Staff felt supported by the management team. The practice manager was also a business partner.
- The practice had a number of policies and procedures to govern activity and staff knew how to access them. Business planning meetings were held and an action plan had been developed.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff.
- The practice worked in partnership with patients and staff and proactively sought feedback, which it acted on. The patient participation group was active and contributed to improving outcomes for patients.
- The practice had an annual staff away day involving GPs, the nursing lead and practice manager which looked at strategies for the future.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

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

- The practice had assessed and modified the care provided to address the needs of older people in its population.
- The practice offered flexible appointments and we saw reception staff were flexible in their approach when dealing with older people that attended the practice in person or who telephoned for appointments. A wheelchair was provided by the practice for patients with mobility difficulties.
- The practice had a robust call and recall system to ensure older people attended appointments when necessary and was responsive to the needs of older people. Patients aged 75 and older had a named GP. Patients aged 80 or older had access to same day appointments without triage. Home visits were also available for patients with enhanced needs.
- The practice provided a flu clinic for patients accommodated in a local sheltered housing scheme and care homes. They visited local care homes weekly to review patients and provide patients with continuity of care.
- Repeat dispensing dosette (medicine) boxes were available for patients on 28-day prescriptions and were monitored by the pharmacist employed by the practice.
- The practice had been proactive in producing care plans for vulnerable older people.

People with long term conditions

Good

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

- The practice provided a large medical and clinical team. All GPs within the team led on a particular long term condition/ speciality. They were supported by the nursing team that also provided specific and advanced knowledge in their chose clinical areas, for example respiratory management.

Summary of findings

- The practice provided a 'one stop shop' for patients with multiple conditions involving the senior health care assistant, nurse and pharmacist. The practice told us the recent addition of a pharmacist had provided specialised support to patients taking multiple medicines and those with complex needs. The pharmacist also specialised in the management of hypertension.
- The practice offered specialist clinics to address the needs of patients with long-term conditions such as diabetes, asthma and hypertension.
- Performance for the five diabetes related indicators was better or comparable to the local and national averages. For example, the percentage of patients with diabetes, on the register, in whom a blood pressure reading was recorded was 79% compared with the local average of 73% and national average of 78%.
- Longer appointments and home visits were available when needed.
- Patients had a structured annual review to check their health and medicines needs were being met and were supported by a multi-disciplinary team.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- The practice had dedicated leads for children's care, women's health and sexual health.
- The practice provided a full range of contraception services including oral contraception, implant fitting and coil insertion with a GP and were hoping to develop an emergency contraception service.
- Patients under five years old had access to same day appointments without triage. Appointments were available outside of school hours and the premises were suitable for children and babies.
- 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 protection plans in place. Children who did not attend appointments were followed up or reported to the health visitor.

Summary of findings

- Immunisation rates were comparable to local averages for all standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 80%, which was the same as the CCG and slightly lower than the national average of 82%.
- The health visiting team were based at the practice and accessible for patients and staff.
- Staff had developed positive working relationships with school nurses and health visitors. A baby clinic, child immunisations and antenatal clinics were held on site. A breast-feeding area was available.

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. The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered a range of appointments at different times of the day, including early mornings and late evenings to allow flexibility for patients.
- A range of online services were available, including booking appointments, prescriptions and access to health medical records. Pre-bookable telephone consultations were also available. The practice had recently introduced a triage system for same day appointments.
- The practice utilised the electronic prescribing system (EPS) which meant prescriptions could be sent directly to the patient's chosen pharmacy at the time of the consultation. The practice were actively promoting the use of repeat dispensing, where appropriate and the practice pharmacist was leading on this initiative.
- The practice used the appointment reminder text service to remind patients of their appointments.
- A chlamydia testing service was available to young people up to the age of 25.

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.

Summary of findings

- The practice displayed information in the waiting area about how to access local support groups and voluntary organisations.
- Staff had developed a 'gold star' board. This provided staff with instant access to valuable information about patients' needs and helped with prioritising appointments.
- There were themed notice boards to encourage uptake of chlamydia screening in addition to information on contraception.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. They held a register of vulnerable patients but the coding of vulnerable adults was not robust.
- 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.
- The practice held a carers register and written information was available to direct carers to the various avenues of support available to them.
- Where information had been shared, the practice had access to vulnerable patients' key codes to gain access to their homes. Their next of kin was documented in their care plan to enable staff to contact them urgently.
- Two GPs led on the care of patients with a learning disability. Longer appointment times were available and annual physical health checks were offered.
- The majority of patients' first language was English, however a translation service was available if needed.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice had a designated lead GP in mental health.

Summary of findings

- Patients with severe poor mental health were invited for an annual review of their health including a full physical and mental assessment with the practice nurse and Community Mental Health Nurse who attended the practice fortnightly.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. Social workers were based in the practice and therefore were readily accessible.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had a good understanding of how to support patients with mental health needs and dementia. The pharmacist had experience in mental health and was also employed at a local Mental Health Trust.
- The use of dossette boxes supported people with the management of their medicine and enabled the pharmacist to quickly identify if patients had not taken their medicine as prescribed.
- Double appointments were offered to allow sufficient time to deal with any complex issues that may be relevant to a patient's health and care.

Summary of findings

What people who use the service say

We reviewed the national GP patient survey results, which were published in January 2016. The survey invited 238 patients to submit their views on the practice, 126 forms were returned. This was a response rate of 53%, which was higher than the national response rate of 38%. The practice performance scored higher in the majority of areas than local and national averages.

- 77% of patients found it easy to get through to this practice by phone which was the same as the local average and higher than the national average of 73%.
- 89% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 77% and the national average of 76%.
- 91% of patients described the overall experience of this GP practice as good compared to the local average of 88% and national average of 85%.
- 87% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 82% and national average of 79%.

We spoke with eight patients on the day of the inspection and invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 17 completed cards. Feedback highlighted a high level of patient satisfaction with many patients describing the level of service they received as “excellent”. Patients commented that they found staff caring, compassionate, professional, and responsive to their individual needs.

Penkridge 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 adviser and a practice manager specialist adviser.

Background to Penkridge Medical Practice

Penkridge Medical Practice is located in semi-rural location in Stafford and is registered with CQC as a partnership provider. The provider holds a General Medical Services contract with NHS England and is a member of the Stafford and Surrounds CCG along with 13 other practices. The premises is purpose built, providing services over two floors. A lift is available to support patients with mobility difficulties. A pharmacy is attached to the building and third party providers work from the premises to include a number of other health and social care professionals.

The building is leased and the practice is managed by six GP partners, two males and four females. The partners are assisted by one male and one female salaried GPs, three nurses and three health care assistants. The administration team consists of a practice manager, a deputy practice manager and a team of secretaries, administrators and receptionists. The practice is an accredited GP training practice and supports medical students.

The practice is open from 8am to 6.30pm on a Monday, Tuesday and Friday and from 8am to 7.45pm on a Wednesday and Thursday. The practice is closed from 12 noon to 2pm on a Thursday for staff training.

- Consultation times with GPs are available in the mornings from 8.30am to 11.30am and in the afternoon from 3pm to 6pm.
- Consultation times with Nurses are available in the mornings from 8.30am to 12 noon and in the afternoons from 3pm to 6.10pm. Phlebotomy appointments are available from 8.30am to 11am and from 2pm to 3.40pm.

When the practice is closed patients are advised to call the NHS 111 service or 999 for life threatening emergencies. The nearest hospital with an A&E unit is the County Hospital, Stafford; however, this is not a 24-hour service. The nearest minor injuries hospital is in Cannock.

The practice serves a population of around 10,000 patients living in the Stafford and Surrounds CCG area. The population distribution shows slightly higher national average numbers of patients aged 55 years of age in comparison with England averages. The percentage of patients with a long-standing health condition is 64%, which is higher than the local and national averages of 54%. The practice is in a less deprived area with unemployment levels comparable to the national average.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before the inspection, we reviewed the information we held about the practice. We also reviewed intelligence including nationally published data from sources including Public Health England and the national GP Patient Survey published in January 2016. We carried out an announced visit on 7 June 2016.

During our visit, we spoke with a range of staff including GPs, the practice manager (business partner), deputy practice manager, practice nurses, health care assistants, secretaries and receptionists. We also spoke with eight patients and three members of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. We also reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service. We observed interactions between patients and staff and reviewed records relating to the management of the practice.

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 were provided for specific groups of people and what good care looked 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).

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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

- There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and we saw there was a recording form available on the practice's computer system. The practice had recorded six serious untoward incidents in the previous year. These were investigated and discussed at educational meetings and practice meetings. However, minutes of discussions held were not effectively shared with staff, for example via email. Not all staff we spoke with were able to recall examples or outcomes of recent serious untoward incidents and the practice had not carried out a thorough or an annual analysis of incidents to identify any common trends, maximise learning and help mitigate errors.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.

We saw the practice had a system to act upon medicines and equipment alerts issued by external agencies to include alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Staff told us when the practice received the patient safety alerts these were saved onto the computer system and circulated to the relevant teams for comments, actions and completion. Staff were happy with the procedure and were able to provide an audit trail of actions taken in response to alerts received.

Overview of safety systems and processes

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Staff knew what constituted abuse and who to contact if they had concerns about a patient's welfare. Staff were made aware of children on the child protection register by alerts on their electronic records and received information shared by other agencies including children who frequently attended hospital. However, there was not a system in place for uniquely coding patients who were vulnerable adults. We saw information about safeguarding matters were displayed in consultation rooms and treatment rooms so information was easily accessible to staff. Staff had access to safeguarding polices on the computer system and these clearly outlined who to contact for further guidance. Staff knew who the lead GPs were for safeguarding adults and children. GPs had received level three training, practice nurses level two and other staff had received level one. The practice shared an example of the actions learnt regarding a vulnerable person receiving respite care at a nursing home who shared the same name as an existing patient. The practice had a good working relationship with the health visitor and school nurses, which helped facilitate any concerns regarding children. Monthly multi-disciplinary meetings were held and these provided opportunity for sharing safeguarding concerns.
- We saw patients were offered a chaperone if required. A chaperone policy was in place designed to protect patients and staff from abuse or allegations of abuse and to assist patients to make an informed choice about their examinations and consultations. Notices were displayed offering this service, which was provided by nurses and healthcare assistants who had received chaperone training and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We observed the premises to be clean and tidy. The nurse team leader was the infection control clinical lead. Discussions with the lead and staff demonstrated they had a clear knowledge of their role and responsibility in ensuring appropriate standards of cleanliness and hygiene were maintained across the practice. There was an infection control protocol in place and staff had received training. Annual infection control audits to include a cleaning control of substances hazardous to health (COSHH) and clinical waste were undertaken. We saw evidence that an action plan had been developed to address any improvements identified as a result. Cleaning schedules were maintained.
- Most of the arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions, which included the review of high-risk medicines. We found blank prescription pads were

stored securely although their issue was not tracked in line with guidance by NHS Protect. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. The practice funded a part time pharmacist and had liaised and sought advice from the local medicines management team when required. There was good liaison with local pharmacies to ensure patients got their medicines as prescribed and safely.

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them. We saw controlled drugs were stored securely. Stocks held had not been used in the last 12 months. However, we found there was no effective system in place to monitor when controlled drugs had expired. For example, records showed two controlled drugs with expiry dates of 2011 and 2014 had not been destroyed until the day before the inspection. The controlled drugs policy also required updating to reflect current practice. Following the inspection, the provider advised us they would no longer be keeping controlled drugs on the premises.

- We reviewed four personnel files and found most recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and the appropriate checks through the Disclosure and Barring Service. However, no written risk assessment had been completed for a clinician who had been in post for four months prior to receiving their DBS check. We were advised that the clinician carried out restrictive work only and had been supervised during this period. We identified that only verbal checks had been obtained from a neighbouring practice on a locum GP who had worked at the practice one day. Evidence of interviews held with prospective staff were only available on one of the four files we reviewed. The shortfalls we identified did not reflect the providers' recruitment policy in relation to safe, effective recruitment practices.

Monitoring risks to patients

Most risks to patients were assessed and managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. A fire risk assessment had recently been carried out and the practice manager reported they were in the process of addressing the required actions for improvement to include arranging fire training for staff and appointing designated fire marshals for each floor. A fire drill had recently been carried out and the practice was successfully evacuated. We saw weekly tests were carried out on the fire system and procedures in the event of a fire were displayed in most rooms and in public areas.

- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as the control of substances hazardous to health.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us they covered colleagues with similar roles during periods of annual leave or sickness.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency.

- We saw emergency medicines held at the practice were checked regularly and were in date and stored securely. They were accessible to staff and held in a secure area. Staff spoken with knew of their location and what action they would take in the event of a medical emergency.

- Staff received annual basic life support training and there were emergency medicines available in the treatment room.

- The practice had emergency equipment, which included an automated external defibrillators (AEDs), (which provides an electric shock to stabilise a life threatening heart rhythm) and oxygen with masks.

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure

or building damage. The plan included emergency contact numbers for staff and had been reviewed to reflect staff changes. Copies of the plan were kept off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and discussed these during the education meetings held. They used the information to deliver care and treatment that met patients' needs. For example, the practice had designed a leaflet based on NICE guidance about effective behaviour change for diabetic and pre-diabetic patients.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The practice used the Map of Medicine to facilitate referrals along accepted pathways. This provided comprehensive, evidenced based local guidance and clinical decision support at the point of care and is effective in reducing referrals. We saw the majority of referrals were sent electronically and a request receipt obtained to enable a good audit trail. The secretary team followed up referrals and coded the patient record accordingly. The patient was advised to contact the practice if they have not received an appointment within 14 days.

Management, monitoring and improving outcomes for people

The practice shared an example of how they involved patients in the management of their own care, for example patients presenting with depression. These patients could be referred by the practice or refer themselves to the Emotional Wellbeing in Stafford and Surrounds (EWISS), a service supporting people experiencing poor mental health. We saw the practice has a lead GP for mental health and worked closely with the crisis team.

A part-time pharmacist was employed by the practice in November 2015. They had provided patients with advice in relation to their medicines in addition to monitoring and improving outcomes for patients. Staff felt the pharmacist played an effective role within the practice and had carried out two audits on medicines prescribed to patients in addition to the introduction of dossett boxes, which helped patients with the management of their medicines.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). QOF results from 2014/15 showed that the practice achieved 99% of the total number of points available; this was higher than the local and national average of 95%. The overall clinical exception reporting for the practice was 13%, which was higher than the CCG rate of 11% and the national rate of 9%. Clinical exception rates allow practices not to be penalised, where, for example, patients do not attend for a review, or where a medicine cannot be prescribed due to side effects. Generally, lower rates indicate more patients have received the treatment or medicine.

The individual clinical domain performance data from 2014/15 showed:

- The percentage of patients with asthma that had a review of their condition within the preceding year was 85%. This was higher than the CCG average of 77% and the national average of 75%. Clinical exception reporting was 8% compared with the CCG average of 14% and the national average of 8%.
- Performance for the diabetes related indicators was higher than the CCG and national averages. For example, 79% of patients with diabetes had received a recent blood pressure reading in the previous year, compared with the CCG average of 73% and the national average of 78%. Clinical exception reporting was 13% compared with the CCG average of 11% and the national average of 9%.
- 85% of patients had received a blood test to indicate their longer-term diabetic control, compared to the CCG and national averages of 78%. Clinical exception reporting was 17% compared with the CCG average of 14% and the national average of 11%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured 150/90mmHg or less in the preceding year was 88%. This was above

the CCG average of 81% and the national average of 84%. Clinical exception reporting was 5% compared with the CCG average of 5% and the national average of 4%.

- 97% of patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD) had a review of their condition in the preceding year, compared to the CCG average of 94% and the national average of 90%. Clinical exception reporting was 18%, which was slightly below the CCG average of 19% and higher than the national average of 11%.

There was evidence of quality improvement including clinical audit. The practice had carried out a five clinical audits within the last 12 months. These included audits on minor surgery, histology following surgery, patients prescribed ciprofloxacin (an antibiotic) and an audit of health record documentation for pre-school children known to the health visitor and registered at the practice.

Following a large increase in the number of diabetic and pre-diabetic patients identified by the practice and the challenge providing diabetic nurse appointments, the practice initiated a quality improvement project and offered personalised lifestyle advice to newly diagnosed pre-diabetics. Improvements made were monitored and the evaluation showed that 23 (62%) out of the 36 patients had a reduction in their blood glucose following the lifestyle advice provided by the practice.

The practice had worked with the Clinical Research Network in delivering high quality research opportunities to patients and participated in two studies designed to establish if a course of treatment reduced hospitalisation for ulcer bleeding in patients using aspirin. 877 patients at the practice had signed up for the two trials available.

Effective staffing

The practice had an experienced, trained and motivated team of staff that had the skills, knowledge and experience to deliver effective care and treatment. Staff were supported by the practice to achieve their career aspirations.

- The practice had an induction programme for all newly appointed staff. New staff had a 'buddy' to help them settle into the practice and their role. They were provided with a practice handbook, safety book and received a skill assessment review of their work after three months of employment.
- Training records reviewed showed staff were up-to-date with training to include safeguarding, infection prevention and control, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. One nurse told us they had completed a diploma in asthma management and had attended training in diabetes. A health care assistant told us they had been supported to attend training in phlebotomy (taking blood from a patient). We saw a medical secretary had obtained an advanced diploma for medical secretaries and another secretary had completed training in medical terminology. A GP told us they were a GP appraiser and trainer and attended the local training group.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training, which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring and clinical supervision. Staff told us they had received an appraisal within the last 12 months and were supported in their learning.

Coordinating patient care and information sharing

The practice had a system in place for sharing and receiving information about patients' care and treatment from other agencies such as hospitals, out of hour's services and community services. They demonstrated an understanding

Good

Are services effective?

(for example, treatment is effective)

of their role and responsibilities with ensuring information was managed effectively. This included care and risk assessments, care plans, medical records and investigation and test results.

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff shared the premises with a range of health and social care professionals. They worked together to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Monthly multidisciplinary meetings were held to share information and discuss the care plans of patients with complex needs and patient notes are updated by GPs.
- There was a system in place for monitoring and reviewing patients that attended out of hour's services and hospital. An electronic record was received by the practice and reviewed by the duty GP and the appropriate action taken. We were told that patients received a post discharge courtesy call to check their welfare and a home visit or telephone consultation was arranged to review their care where required.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. They were able to provide us with examples of how they sought consent from patients. For example, one nurse told us they always gained consent from a patient when a medical student was present during a consultation. We saw evidence that written consent had been obtained for a patient prior to an intrauterine device (coil) being fitted. A GP advised us they had received training from the CCG in relation to deprivation of liberty safeguards and had arranged online training for staff.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients at risk of developing a long-term condition and those requiring advice on their diet and smoking cessation were supported and regularly reviewed by the senior health care assistant. Patients were signposted to the relevant service.
- Travel advice and vaccinations were provided by the practice nurse.
- All newly registered patients were invited to attend for a new patient check.
- The practice had dedicated leads for children's care, women's health and sexual health.
- There were themed notice boards to encourage uptake of chlamydia screening in addition to information on contraception.
- The practice were planning to set up a memory clinic.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice's uptake for the cervical screening programme was 80%, which was the same as the CCG average and slightly below the national average of 82%. The practice demonstrated how they encouraged uptake of the screening programme and ensured a female sample taker was available. There was a policy to follow up patients who did not attend for their cervical screening test. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred because of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to the CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 82% to 97% and five year olds from 91% to 99%.

Good

Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health checks for new patients. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

Throughout the inspection, we saw staff were courteous and very helpful to patients who attended or telephoned the practice and observed that patients were treated with dignity and respect.

Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We saw that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. There was a small private room off the waiting room for patients to discuss sensitive issues or to discuss their needs with the reception staff.

We spoke with eight patients on the day of the inspection and invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 17 completed cards. Patients said they felt the practice offered a very good service and staff were helpful, caring and treated them with dignity and respect.

The practice had a patient participation group (PPG). We met with three members of the PPG. They told us the group was established around 2005 and met quarterly and there was also a virtual group. They told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent data available for the practice on patient satisfaction from the national GP patient survey published in January 2016. The survey invited 238 patients to submit their views on the practice, 126 forms were returned. This was a response rate of 53%. Results showed patients felt they were treated with compassion, dignity and respect. The practice scored above or similar to CCG and national averages for its satisfaction on consultations with GPs and nurses. For example:

- 94% of patients said the GP was good at listening to them. This was higher than the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 91% of patients said the GP gave them enough time. This was the same as the CCG average and higher than the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 85%.
- 95% of patients said the last nurse they saw or spoke with was good at listening to them compared to the CCG average of 92% and the national average of 91%.
- 99% of patients said the last time they saw or spoke with a nurse they were good at giving them enough time. This was higher than the CCG average of 94% and the national average of 92%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt listened to and had sufficient time during consultations and felt involved in decision making about the care and treatment they received. Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 89% of patients said the last GP they saw was good at explaining tests and treatments. This was the same as the CCG average and higher than the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 82%.
- 92% of patients said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%
- 98% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.
- The practice provided facilities to help patients be involved in decisions about their care. Translation

services were available for patients to access if English was not their first language. We saw care plans were developed in partnership with each patient and their close relatives, for example patients with dementia.

Patient and carer support to cope emotionally with care and treatment

We saw patient information leaflets and notices were displayed in the waiting area which told patients how to access a number of local support groups and organisations, for example the local crisis support scheme. Health and social care professionals were based within the building and therefore this helped with coordinating patient care.

The practice's computer system alerted staff if a patient was also a carer. The practice had identified 98 patients as carers (1% of the practice list). We saw information was available that signposted carers to local support organisations. This included a local day centre offering a range of opportunities in support of older people at varying stages of dementia and other complex needs. Patients could be referred there by the practice to give their carers a break. The practice were planning to provide a notice board in the waiting area for Carers Week. This is an annual campaign to raise awareness of caring, highlight the challenges carers face and recognise the contribution they make to families and communities throughout the UK. The practice acknowledged the need to increase the number of carers on their register and were considering involving the PPG to raise patient awareness and ensure staff correctly code patients who are carers.

The practice was an official foodbank agency voucher provider for emergency food for local people in crisis. Staff were proud of the practices links with the food bank run by a church in Hendesford. Staff had contributed to provide a hamper of gifts for two families in need during the festive period.

GPs visited patients who had experienced bereavement of a close family member. We were told they had also attended funerals of patients who had been known to the practice for a number of years. We saw staff had access to the names of patients who had recently passed away.

Where information had been shared, the practice had access to vulnerable patient's key codes to gain access to their homes, for example patients with dementia. Their next of kin was documented in their care plan to enable staff to contact them urgently.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice manager and a GP attended monthly locality meetings arranged by the CCG. These meetings provided opportunities for networking and sharing good practice. The practice provided a large medical and clinical team. All GPs within the team led on a particular long term condition/ speciality. They were supported by the nursing team that also provided specific and advanced knowledge in their chose clinical areas, for example respiratory management.

- There was an alert on the electronic records for patients with a learning disability and those with a visual or hearing difficulties to alert staff. These patients were met and greeted in the waiting room by clinicians for their appointments.
- Priority was given to patients under the age of five, over the age of 80 and those identified on a 'gold star' board that provided staff with instant access to valuable information about patients with complex needs when prioritising appointments.
- Home visits were available for older patients and patients who had clinical needs, which resulted in difficulty attending the practice.
- Flu clinics were also held for patients living in care homes and sheltered living accommodation. The practice visited local care homes weekly to review patients and provide patients with continuity of care.
- Same day appointments were available for young children, patients with medical problems that required same day consultation and people from travelling communities.
- Access for patients had improved through the implementation of a telephone triage system. Patients requiring a same day appointment were telephoned by a GP. The GP had the options to suggest an appointment slot, issue a prescription or offer a same day appointment.
- The practice provided online services for patients to book appointments, order repeat prescriptions and access a summary of their care records.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available although English was the first language of the majority of patients currently registered at the practice.
- Staff received annual training in equality and diversity.
- A passenger lift was available providing access to services on the first floor.
- The practice used the appointment reminder text service to remind patients of their appointments.
- The practice utilised the electronic prescribing system (EPS) which meant prescriptions could be sent directly to the patient's chosen pharmacy at the time of the consultation. The practice were actively promoting the use of repeat dispensing, where appropriate and the practice pharmacist was leading on this initiative.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. The practice was closed between 12 noon and 2pm on Thursdays for staff training. Appointments with GPs were from 8.30am to 11.30am and 3pm until 6pm. Appointments with nurses were available from 8.30am to 12 noon and 3pm until 6.10pm. Phlebotomy services were available from 8.30am to 11.00am and from 2pm until 3.40pm. Extended hours appointments were offered from 6.30pm to 7.50pm on a Wednesday and Thursday. Telephone consultations were available each weekday. Urgent appointments were also available for people that needed them, for example children aged five and under. Home visits were carried out after 11.30am. Some clinics were held during the middle of the day and in extended hours for people with long-term conditions. The practice had a duty GP available each weekday to assess whether a home visit was clinically necessary; and the urgency of the need for medical attention.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher compared to local and national averages.

- 84% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 78%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 77% of patients said they could get through easily to the practice by phone, which was the same as the CCG average and higher than the national average of 73%.

All but one patient told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.

We looked at seven complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. The practice manager was the business partner and was responsible for dealing with complaints. They acknowledged complaints were dealt with and addressed but not always recorded to help identify any trends in complaints to improve the quality of the service provided. They told us they aimed to improve this. We saw that the complaints procedure was included in the patient guide. A separate leaflet was also available detailing how to make a complaint, however this was not readily accessible to patients but was available on the practice website. None of the patients we spoke with were aware of the complaints procedure but told us they had not had a cause to use it.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- Staff told us the values for the practice were shared during their induction.
- The practice had strategy and supporting business plans, which reflected the vision and values and were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Staff understood how to access specific policies and we saw these were available to all staff.
- Clinical meetings were held monthly and recorded in addition to business planning meetings and an action plan developed.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection, the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Staff told us the practice manager and partners promoted an open culture and were approachable and always took the time to listen them. Staff felt valued and supported within their role. Social evenings were regularly held and the practice had supported a number of staff with partaking in a charity event. The practice had an annual staff away day involving GPs, the nursing lead and practice manager which looked at strategies for the future.

- The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment. They gave affected people reasonable support, truthful information and an apology.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us they attended team meetings and had protected learning time.
- Staff told us they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG), known as Penkridge Patient Link and through surveys and complaints received. The PPG were well established and met quarterly. They had carried out a patient surveys in 2015 and submitted proposals for improvements to the practice management team. For example, improvements around access to appointments and the telephone system, which the partners were looking to replace shortly in addition to revamping the practices website. We saw the PPG had a notice board and leaflets displayed in the waiting area detailing the aims of the

Are services well-led?

Good

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

group and welcoming comments and suggestions for improvement. Representatives of the group told us speakers had attended the practice and provided talks to patients on various subjects including the care for the elderly and medicine wastage. They said they had spent time at the practice educating patients to use the self-check in system to help free up reception staff time. They also trialled the on-line appointment system and provided feedback to the partners. They produced a detailed patient information leaflet in addition to a list of support groups available for patients to access should they need to.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussions held with staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The partners told us they had received positive feedback from a local university about their teaching.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The staff we spoke with told us they felt supported to develop professionally. The practice had recently employed a part-time pharmacist that enhanced the skills of the clinical team. They provided specialised support to patients taking multiple medicines and those with complex needs.

The practice was involved in research and had worked with the Clinical Research Network in delivering high quality research opportunities to patients. They had participated in two studies designed to establish if a course of treatment reduced hospitalisation for ulcer bleeding in patients using aspirin. 877 patients at the practice had signed up for the two trials available.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** The provider did not have effective systems and processes in place to identify patients who were vulnerable adults.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** People using the service were not protected against the risks of inappropriate or unsafe care and treatment because the required information as outlined in Regulation 19 and Schedule 3 (Information required in respect of persons seeking to carry on, manage or work for the purposes of carrying on a regulated activity) had not been obtained.