

# Cobridge Surgery

## Quality Report

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

### Ratings

|  |                             |   |
|--|-----------------------------|---|
| <b>Overall rating for this service</b>     | <b>Good</b>                 |  |
| Are services safe?                         | <b>Requires improvement</b> |  |
| Are services effective?                    | <b>Good</b>                 |  |
| Are services caring?                       | <b>Good</b>                 |  |
| Are services responsive to people's needs? | <b>Good</b>                 |  |
| Are services well-led?                     | <b>Good</b>                 |  |

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cobridge Surgery on 2 September 2015. Overall the practice is rated as good.

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.

Our key findings were as follows:

- Staff knew how to and understood the need to raise concerns and report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and acted upon.
- Although the practice had not developed practice specific risk assessments, risks to patients had been assessed and were well managed.

- Best practice guidance was used to assess patients' needs and plan and deliver their care. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patient information, including how to complain was available and easy to understand.
- Patients told us they could usually get an appointment when they needed one, with urgent appointments available the same day. They also told us they may have to wait up to a week for a pre bookable appointment.
- The practice was located in a purpose build health centre with good facilities and suitable equipment to treat and meet patients' needs.
- There was a clear leadership structure and staff felt supported by management.

# Summary of findings

We saw one area of outstanding practice:

- Stickers had been developed for children which incorporated a QR (quick response) code for smart phones. This took the user to the common childhood illnesses booklet on the practice website, which could be downloaded on the phone for future reference.

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

Importantly the provider must:

- Ensure that all necessary pre-employment checks are obtained and appropriate evidence kept on file.

The provider should:

- Consider having a designated lead for infection control and carry out infection control audits.
- Develop practice specific risk assessments.
- Review and update the disaster handling and recovery protocol.
- Consider recording informal / verbal complaints.
- Consider developing a strategic plan to support the delivery of the practice values and any future developments.
- Carry out risk assessment to ensure the safety of confidential information within the practice.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as requires improvement for providing safe services. There was a system in place for reporting, recording, monitoring and reviewing significant events, 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 although there were no written practice specific risk assessments and infection control audits were not completed. Records did not support that all the necessary employment checks had been obtained before staff started their employment. There were enough staff to keep patients safe.

Requires improvement



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. One of the GP partners oversaw any changes to guidelines and updated the electronic assessment templates accordingly. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and further training needs have been identified and appropriate training planned to meet these needs. The practice worked closely with the Integrated Local Care Team (with representatives from both health and social care services) to ensure care plans were in place and regularly reviewed for patients at risk of unplanned admissions.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients told us they were treated with compassion, dignity and respect. They described staff as being helpful and caring. Good systems were in place to support carers and patients to cope emotionally with their health and condition. Information to help patients understand the services available was easy to understand. Views of external stakeholders such as other health care professionals were positive and aligned with our findings.

Good



# Summary of findings

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the local Clinical Commissioning Group (CCG) and community NHS trust to plan services and to improve outcomes for patients. The practice worked closely with the community health promotion staff nurse to support patients from black and minority ethnic groups. Patients told us they could usually get an appointment when they needed one, although they may have to wait up to a week for a pre bookable appointment with a GP. Patients who required an urgent appointment would be seen 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. However, the practice did not record informal / verbal complaints.

Good



## Are services well-led?

The practice is rated as good for being well-led. There had been changes in the management structure and clinical staff at the practice. One of the partners had retired in March 2015, leaving the two current partners. One of these partners was due to leave the partnership at the end of September 2015. The remaining partner was considering a range of options to ensure the continuity of the practice. As a consequence, the practice did not have any strategic plans in place to support the delivery of the practice values or **any long term future developments**. Staff told us that there was an open culture within the practice and they were able to raise any issues and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice. The practice had an established Patient Participation Group (PPG). 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.

Good



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people. Every patient over the age of 75 years had a named GP. 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 end of life care and avoidance of unplanned admissions. It was responsive to the needs of older people and offered home visits and open access appointment for patients over the age of 65 years. The practice identified if patients were also carers and offered opportunistic health checks and advice.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. We found that the nursing staff had the knowledge, skills and competency to respond to the needs of patients with a long term condition such as diabetes and asthma. All of these patients were offered a review to check that their health and medication needs were being met. The practice had developed a range of information leaflets / action plans for patients with long term conditions. These included diabetic foot care, personal asthma action plan and winter care plan for chronic lung disease (which also included giving patients emergency medication). For those people with the most complex needs, the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, children and young people who had protection plans in place. The practice offered open access for children and same day emergency appointments were always available. There were screening and vaccination programmes in place and the immunisation rates although a number of the immunisation rates were below the local Clinical Commissioning Group average. We saw good examples of joint working with midwives and health visitors. The practice had developed stickers for children which incorporated a QR (quick response) code for smart phones. This took the user to the common childhood illnesses booklet on the practice website, which could be downloaded on the phone for future reference. The practice had developed a range of information leaflet to assist parents of children who have viral wheeze.

Good



# Summary of findings

## **Working age people (including those recently retired and students)**

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. A range of on-line services were available, including medication requests, booking appointments and access to health medical records. The practice does not offer extended hours but would see any patient who required an urgent appointment. The practice offered all patients aged 40 to 75 years old a health check with the practice nurse. The practice offered a full range of health promotion and screening that reflected the needs for this age group.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice population was culturally diverse and we found that the practice enabled all patients to access their GP services. Staff made use of language line to support patients whose first language was not English. The practice held a register of patients with a learning disability and developed individual care plans for patients. The practice carried out annual health checks and offered longer appointments for patients with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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.

Good



## **People experiencing poor mental health (including people with dementia)**

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice was a pilot site for handing out self-referral slips for the locally commissioned Healthy Minds service (a psychological service for common mental health problems). Patients also had access to a counsellor who visits the practice weekly. The practice worked closely with a local care home caring for people living with dementia, and had identified patients on antipsychotic medication and made referrals to psychiatric services for review. The practice also supported staff with capacity assessments and deprivation of liberty safeguards.

Good



# Summary of findings

## What people who use the service say

We spoke with 13 patients during the inspection and collected 36 Care Quality Commission (CQC) comment cards. Patients were positive about the service they experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. They said the GPs listened and understood their needs and they were involved in decisions about their care. Comment cards highlighted that staff were friendly, polite and helpful and treated patients with dignity and respect.

The national GP patient survey results published on 2 July 2015 showed that overall the practice was performing broadly in line with local and national

averages. There were 101 responses and a response rate of 25.6%. The results indicated the practice was above average in aspects of care, including speaking to or seeing the same GP. For example:

- 80% of respondents with a preferred GP usually get to see or speak to that GP compared with a CCG average of 62% and national average of 60%.
- 91% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 93% said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 91% said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 81%.

## Areas for improvement

### Action the service MUST take to improve

Ensure that all necessary pre-employment checks are obtained and appropriate evidence kept on file.

### Action the service SHOULD take to improve

Consider having a designated lead for infection control and carry out infection control audits.

Develop practice specific risk assessments.

Review and update the disaster handling and recovery protocol.

Consider recording informal / verbal complaints.

Consider developing a strategic plan to support the delivery of the practice values and any future developments.

Carry out risk assessment to ensure the safety of confidential information within the practice.

## Outstanding practice

Stickers had been developed for children which incorporated a QR (quick response) code for smart phones. This took the user to the common childhood illnesses booklet on the practice website, which could be downloaded on the phone for future reference.



# Cobridge Surgery

## 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, a practice nurse specialist adviser and an Expert by Experience.

### Background to Cobridge Surgery

Cobridge Surgery is situated in the Cobridge area of Stoke on Trent which is one of the most deprived areas in the country. The practice population is culturally diverse and transient. The practice is located within the Cobridge Health Centre which also accommodates a range of health care services and another GP practice. At the time of our inspection there were 4412 patients on the patient list.

The practice has two GP partners (although one was due to leave at the end of September 2015), a practice nurse, practice manager and reception and administration staff.

The practice is open from 8.30am until 6.30pm every day except Thursdays, when the practice closes at 1pm. Appointments were available from 8.50am to 11am and 2.30pm to 5pm. Patients could telephone the practice from 8am. Patients requiring a GP outside of normal working hours are advised to contact the practice and they will be directed to the out of hours service. This is provided by Staffordshire Doctors Urgent Care Limited. The practice has a GMS (General Medical Services) contract and also offers enhanced services for example: various immunisation schemes.

### Why we carried out this inspection

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

### How we carried out this inspection

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

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

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

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

## Detailed findings

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 2 September 2015.

We spoke with a range of staff including the GP partners, the practice nurse, the practice manager, and reception and administration staff. We sought the views from a representative of the patient participation group, looked at comment cards and reviewed survey information. We also spoke with representatives from a local care home, the health visiting service and the local NHS community trust.

# Are services safe?

## Our findings

### Safe track record and learning

The practice had a system in place for reporting, recording and monitoring significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. There was an electronic system in place for recording significant events. Staff told us they would inform the practice manager of any incidents. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared between the GPs to make sure action was taken to improve safety in the practice. For example, the hospital had queried the dosage of a certain medication for a patient, which had been incorrectly prescribed. As a consequence, the practice carried out an audit to ensure that patients prescribed this type of medication were on the correct dose, which they were. The practice planned to repeat the audit to ensure patients continued to be prescribed the correct dosage. The practice told us that incidents (both positive and negative) were also reported on Datix. Datix is an electronic system for reporting incidents and adverse events. The information was shared with the local Clinical Commissioning Group and the local NHS trust.

### Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. Information about who to contact for further guidance if staff had concerns about a patient's welfare was available in the policy and contact details were displayed in the consulting rooms. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.

The practice held registers for children at risk, and children with protection plans were identified on the electronic patient record. Safeguarding was a standing agenda item at the weekly clinical meetings. The practice had established a good working relationship with the health visiting team. We spoke with a representative from the

health visiting team. They told us the doctors had an open door policy and were proactive about sharing any concerns about families and acting on information received from the health visitors.

A chaperone policy was available to all staff. The practice nurse and two members of non clinical staff acted as chaperones if required and notices in the waiting room and consulting rooms advised patients the service was available should they need it. All staff had received training to carry out this role. However, the non clinical staff who acted as chaperones had not received a Disclosure and Barring Service (DBS) check. The risk assessment did not clearly demonstrate why DBS checks were not required. An updated risk assessment was forwarded within 48 hours of the inspection.

### Medicines management

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medicine audits were carried out to ensure the practice was prescribing in line with best practice guidelines. We looked at one audit with regard to the prescribing of blood glucose (sugar) testing strips for diabetic patients. The initial audit had been carried out to assess that the testing strips had been prescribed in line with the guidance and to reduce the overall cost. As a consequence, a number of prescriptions were amended to reflect the actual usage of the testing strips, and the practice guidance was updated. The second audit demonstrated an improvement in prescribing in line with the guidance and a reduction in the overall prescribing costs. We saw from the data we reviewed that the pattern of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were similar to national prescribing.

The practice had two fridges for the storage of vaccines. The practice nurse took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccinations and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily. Regular stock checks were carried out to ensure that medicines were in date and there were enough available for use.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

# Are services safe?

## Cleanliness and infection control

All areas within the practice were found to be visible clean and tidy. Comments we received from patients indicated that they found the practice to be clean.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Clinical waste disposal contracts were in place and spillage kits were available.

There was an infection control policy in place and all staff had received infection prevention and control training. It was not clear which member of staff was the designated clinical lead for infection control and infection control audits had not been carried out. The landlord of the building was responsible for cleaning all areas. Cleaning schedules were in place and monthly audits carried out. A legionella risk assessment had been completed and procedures were in place to prevent the growth of legionella.

## Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment maintenance logs that demonstrated that all electrical equipment had been tested and maintained regularly. For example, all portable electrical equipment had been tested in October 2014 and medical devices were calibrated in November 2014 to ensure they were safe to use.

## Staffing and recruitment

There were usually sufficient numbers of staff with appropriate skills to keep people safe. Reception and administration staff were offered overtime to cover holidays and sickness. The practice occasionally employed locum GPs. We saw that the practice had obtained copies of the necessary recruitment and safety checks from the agency, prior to the locum GP working at the practice.

Records showed that not all appropriate checks were undertaken prior to employing staff. Identification checks were missing in the two files we reviewed, and the employment history dates did not include months and years. In addition the Disclosure and Barring Service (DBS) check for the practice nurse had been undertaken after they had been employed.

## Monitoring safety and responding to risk

The practice had limited systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. A number of risk assessments had been completed by the landlord of the building, for example legionella. The practice did not have a risk log in place and had not developed any of their own written risk assessments. However, the practice had identified risks and acted upon these, for example, covers had been fitted to the electrical sockets in the treatment room used for child immunisations.

## Arrangements to deal with emergencies and major incidents

There were emergency procedures and equipment in place to keep people safe. Emergency medicines were available in the treatment room and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and 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. Staff had received cardio pulmonary resuscitation training, and a defibrillator was available, which staff were trained to use.

The practice had a protocol for disaster handling and recovery in place for major incidents such as power failure or building damage. However, the plan was out of date as it had not been updated since 2008 and did not reflect that the practice had moved to Cobridge Community Health Centre.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Clinical staff routinely referred to guidelines from the National Institute for Health and Care Excellence (NICE) when assessing patients' needs and treatments. There was a system in place to inform staff of any changes in the NICE guidelines they used. One of the GP partners had the lead role to oversee any changes to guidelines and updated the electronic assessment templates accordingly.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register. The practice took part in the avoiding unplanned admissions scheme. The clinicians reviewed their individual patients and discussed patient needs at formal meetings with the Integrated Local Care Team (with representatives from both health and social care services) to ensure care plans were in place and regularly reviewed.

### Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against the national screening programmes to monitor outcomes for patients. The practice achieved 96.6% of QOF points which was above the local Clinical Commissioning Group (CCG) (92.7%) and national average (94.2%). This practice was an outlier for two of the QOF clinical targets, one relating to the management of diabetes and the other relating to the prevalence of coronary heart disease. Data from 2013-2014 showed:

- Performance for diabetes related indicators was better than the national average, with the exception of patients with a blood sugar level within the recommended range.
- The percentage of patients with hypertension whose blood pressure was within the recommended range was better than the national average.
- The dementia diagnosis rate was comparable to the CCG and national average.

The practice carried out a range of audits which included clinical audits. The practice showed us a number of clinical

audits that been undertaken. We looked at one medicine audit with regard to the prescribing of new type of medication for diabetes. The audit had been carried out to assess that the new medication delivered the benefits as outlined in the promotional literature, for example weight loss and better control of blood sugar levels. The initial audit demonstrated improved outcomes for the 16 patients included in the audit. The second audit cycle carried out six months later demonstrated that the improved outcomes for patients had been maintained.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- An individualised induction programme had been developed for the practice nurse taking into account her previous experience and skills required for her new role.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and infection control.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between service, when they were referred, or after they are

# Are services effective?

(for example, treatment is effective)

discharged from hospital. We spoke with a health visitor and a representative from a local care home as part of this inspection. They told us the practice worked with them to meet the needs of patients and that there were effective communication pathways in place to support the sharing of information. 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. The co-ordinator of the Integrated Local Care Team (ILCT) told us the GPs were proactive if issues arose. For example, a patient was discharged from hospital without an aftercare / rehabilitation package in place. The patient was seen by one of the GPs who liaised with the ILCT to organise an individualised care package for the patient.

## Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and sought advice from the advocacy service. Clinical staff had attended training on the Mental Capacity Act. One of the GPs told us they worked closely with staff at a local care home to ensure patients living with dementia had their capacity assessed appropriately and deprivation of liberty safeguards were taken into account.

## Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers and those requiring

advice on their diet, smoking and alcohol cessation or counselling. Patients were referred to the relevant service for weight management and alcohol cessation advice. Patients could also be referred to counselling services.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 76.8% which was broadly similar to the national average of 81.8%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice held a Bowel Cancer Awareness Event in conjunction with the Cancer Awareness Team in August 2015.

Childhood immunisation rates for the vaccinations given were comparable to the national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96.5% to 100% and five year olds from 93.9% and 100%. The practice worked closely with the health visiting team, sharing information about patients who do not attend for their immunisations. Flu vaccination rates for the over 65s were 73.6% and for at risk groups 53.2%, both of which was slightly above the national average.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74.

The practice had developed a range of information leaflets / action plans for patients with long term conditions. These included diabetic foot care, personal asthma action plan, winter care plan for chronic lung disease (which also included giving patients emergency medication) and viral wheeze for children. Stickers had also been developed for children which incorporated a QR (quick response) code for smart phones. This took the user to the common childhood illnesses booklet on the practice website, which could be downloaded on the phone for future reference.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients attending at the reception desk and that people were treated with dignity and respect.

We spoke with 13 patients during the inspection and collected 36 Care Quality Commission (CQC) comment cards. Patients were positive about the service they experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. They said the GPs listened and understood their needs and they were involved in decisions about their care. Comment cards highlighted that staff were friendly, polite and helpful and treated patients with dignity and respect.

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. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Facilities were available if the patients wanted to speak with the receptionist in private.

Results from the national GP patient survey published in July 2015 from 101 responses showed that patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 91.4% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 87.8% and national average of 88.6%.
- 93% said the GP gave them enough time compared to the CCG average of 87.2% and national average of 86.8%.
- 100% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.9% and national average of 95.3%
- 93% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85.3% and national average of 85.1%.

- 97.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91.6% and national average of 90.4%.
- 94.1% patients said they found the receptionists at the practice helpful compared to the CCG and national average of 86.9%.

### Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The practice was above average for its satisfaction scores on involvement and decision making. For example:

- 92.6% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85.3% and national average of 86.3%.
- 90.8% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81.2% and national average of 81.5%
- 94.7% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90.3% and national average of 89.71%.
- 91.6% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86.8% and national average of 84.9%.

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

### Patient/carer support to cope emotionally with care and treatment

Notices in the waiting room and information on the practice website told patients how to access a number of support groups and organisations. Staff told us patients could be referred to services such as Healthy Minds or The Dove Service for psychological and emotional support.

## Are services caring?

The practice's computer system alerted GPs and nursing staff if a patient was also a carer. The practice maintained a list of carers, and the GPs told us they currently carried out opportunistic reviews of carers' health, but were working towards annual reviews. The needs of patients and carers were also discussed during the integrated local care team meetings, attended by community nursing services, social services and the GPs.

Staff told us that if patients and their families suffered bereavement the GPs visited the family at home to provide support. Patients could be referred for bereavement counselling if required.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) and local community NHS Trust to plan services and to improve outcomes for patients in the area. For example, the practice worked closely with the community health promotion staff nurse to support patients from black and minority ethnic groups. The staff nurse and practice had recently collaborated to hold an event to provide information for patients with specific conditions about 'fasting' solutions during Ramadan.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- Although the practice did not offer extended hours, any patient who wished to be seen urgently would be seen at the end of surgery.
- There were longer appointments available for people with a learning disability, complex needs or who needed to use the translation service.
- Home visits were offered to patients who were unable to or too ill to visit the practice.
- There were disabled facilities, hearing loop and translation services available.

The practice had an established Patient Participation Group (PPG), although the members recognised that they were not representative of the practice population. 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. We spoke with one member of the group who told us about their activities. They had a regular programme of meetings and planned activities. They had been involved in setting up of information stands in the waiting area, for example diabetes, fire safety and warm housing. They had previously supported the practice with patient surveys. The member told us that there was no formal representation from the practice at the meetings, although there were plans to involve the practice in setting the future direction.

### Access to the service

The practice was open from 8.30am until 6.30pm every day except Thursdays, when the practice closed at 1pm. Appointments were available from 8.50am to 11am and

2.30pm to 5pm every afternoon. Patients could telephone the practice from 8am. The practice did not offer any extended hours. The practice offered a number of appointments each day with the GPs for patients who needed to be seen urgently, as well as pre-bookable appointments. Once the same day appointments had been taken, patients requiring an urgent appointment were seen at the end of surgery. The appointment times for each GP were included in the practice leaflet and on the website. Pre-bookable appointments with the practice nurse were available on Mondays, Wednesdays and Fridays.

Patients told us they could usually get an appointment when they needed one, although they may have to wait up to a week for a pre bookable appointment with a GP. Patients also told us there were some difficulties when telephoning the surgery at 8am as the line was often busy. These comments were similar to those made on the comment cards.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable with or above the local and national averages. For example:

- 82.7% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 78.7% and national average of 73.8%.
- 88.4% patients said they could get through easily to the surgery by phone compared to the CCG average of 75.7% and national average of 74.4%.
- 88.4% patients described their experience of making an appointment as good compared to the CCG average of 77.9% and national average of 73.8%.
- 61.4% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66.5% and national average of 65.2%.

### 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 person who handled all complaints in the practice.

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

Information on how to complain was available on the website and complaint forms were available in reception. Patients we spoke with were aware to speak to reception staff if they wished to make a complaint.

We looked at a summary of three complaints made during the last 12 months and found these had been satisfactorily handled and demonstrated openness and transparency. No themes were identified from the complaints. Staff told

us that they would deal with any verbal / informal complaints as they arose. However these informal complaints were not recorded so could not be reviewed for any trends or themes.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. Complaints were discussed during the weekly clinical meeting.

# 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 leading evidence-based, person-centred care. This was demonstrated through discussions with staff, audits and electronic templates.

There had been changes in the management structure and clinical staff at the practice. Cobridge Surgery was a family practice with family members as partners. One of the partners had retired in March 2015, leaving the two current partners. One of these partners was due to leave the partnership at the end of September 2015. The practice had actively tried to recruit an additional GP but without success. The remaining partner was considering a range of options to ensure the continuity of the practice. As a consequence, the practice did not have any strategic plans in place to support the delivery of the practice values or any long term future developments.

### 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 and worked within their level of competency.
- Practice specific policies were implemented and were available to all staff.
- A system for reporting incidents whereby learning from outcomes of analysis of events actively took place.
- A system of continuous audit cycles which demonstrated an improvement in outcomes for patients.
- Clear methods of communication between clinical staff and other healthcare professionals to disseminate best practice guidelines and other information.
- Acting on concerns raised by patients and staff.

Confidential information was stored securely, although staff from the other GP practice located in the same building also had access. A risk assessment had not been completed to ensure the safety of this confidential information within the practice.

### Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they were able to raise any issues and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice. Although regular clinical meetings were held, an administration /reception staff meeting had not been held for around 6 months.

The practice staff told us they worked well together as a team and there was evidence that staff were supported to attend training appropriate to their roles. The GPs were all involved in revalidation, appraisal schemes and continuing professional development. There was evidence that staff had learnt from incidents and complaints and there was evidence of shared learning between clinical staff.

### Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), NHS Friends and Family Test and complaints received. The practice had an established PPG. 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. The PPG recognised that the group did not include representation from all of the various population groups. We spoke with one member of the group who was positive about the role they played and how they engaged with the practice. They told us they had previously supported the practice with patient questionnaires. Information about the PPG was displayed in the practice and information was available on the practice website.

### Innovation

The practice had developed a number of information leaflets / action plans for patients with long term conditions, to assist with self-management of the condition. Stickers had also been developed for children which incorporated a QR (quick response) code for smart phones. This took the user to the common childhood illnesses booklet on the practice website.

The practice worked with Keele University to provide placements for first and second year medical students and also participated in research projects. The GPs actively trialled new systems for the management conditions, for example management of suspected pneumonia, to assess if there was any benefit for patients. One of the GP partners

# Are services well-led?

Good 

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

regularly updated the electronic templates to reflect changes in clinical guidelines. The practice was part of a

pilot scheme for handing out self-referral slips for the locally commissioned Healthy Minds service (a psychological service for common mental health problems).

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br><b>The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</b><br>Fit and Proper Person Employed<br>People using the service were not protected against the risks of inappropriate or unsafe care and treatment because the required information as outlined 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) was not recorded.<br>Regulation 19(3)(a) |