

# Trent Vale Medical Practice

## Quality Report

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Date of inspection visit: 04/05/2016

Date of publication: 17/06/2016

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

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Trent Vale Medical Practice on 4 May 2016. Overall the practice is rated as good, with requires improvement for safe services.

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 Care Quality Commission at that time.

Our key findings were as follows:

- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Risks to patients were assessed and well managed with the exception of processing safety alerts about some medicines. However, the practice took immediate action to start to mitigate this.
- Staff felt supported and had been encouraged to develop within their role.
- Patients told us they could access an urgent appointment when needed. Although the availability of bookable GP appointments was not as positive.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

We saw an area of outstanding practice:

- The practice used an effective system to maximise the opportunity for patients to receive frequent checks on their wellbeing. Systems to monitor and contact patients to invite them for health assessments had been developed over time. The

# Summary of findings

practice consistently achieved higher than average outcomes in providing follow up care. For example, the practice had 50 patients recorded with a learning disability and they had provided all of the patients with an annual health check. This performance was twice the national average of uptake of the health assessments.

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

Importantly, the provider must:

- Implement a recorded system to receive and act on alerts about medicines that may affect patients' safety.

In addition the provider should:

- Develop the significant event reporting process to maximise learning, including more detailed investigation and review.

- Install an Automated External Defibrillator (AED) in the practice as recommended in the 'Primary care – Quality Standards' published by the Resuscitation Council UK. Alternatively produce a written risk assessment to why an AED is not required.
- Ensure there is comprehensive clinical oversight if future plans to delegate the processing of and acting upon information about patients' care and treatment are implemented.
- Investigate the reasons for the higher than average attendance at A&E by registered patients.
- Consider wider use of the national GP patient survey in the practice systems for acting on patient feedback.

**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.

- The practice had a transparent and widely used system to report and record significant events. We saw the investigation and review of incidents could be improved.
- Risks to patients were assessed and well managed with the exception of processing safety alerts about some medicines. However, the practice took immediate action to mitigate this.
- The practice had effective systems to safeguard children and vulnerable adults and staff were knowledgeable in safeguarding practice.
- The practice had systems in place to help manage unplanned events. These included staff training, and most of the suggested equipment available, for emergencies. Although, the practice did not have an Automated External Defibrillator on site or nearby.

**Requires improvement**



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- The practice had undertaken a high number of clinical audits which demonstrated quality improvement.
- Clinical staff followed national guidance to urgently fast track the referral of patients with symptoms suggestive of cancer.
- Staff were proactive and effective in following patients up regularly to maximise the opportunity of them receiving a health/condition assessment.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

**Good**



### Are services caring?

The practice is rated as good for providing caring services.

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

**Good**



# Summary of findings

- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice offered additional services for carers and had identified of the practice list).

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. Additional services offered on site included avoiding patients unplanned admission to hospital, implant of contraceptive devices and minor surgery.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Data showed patient satisfaction about their experience of making an appointment was lower than local and national averages. The practice was taking some action to improve in this area.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints occurred although, at times, this was not clearly recorded.

## Are services well-led?

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

Good



- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- The practice had comprehensive and effective systems to maximise opportunities to receive follow up care relevant to their condition.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- Staff felt supported and had been encouraged to develop within their role.

# 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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- We saw examples where the practice had proactively and quickly responded to concerns about the wellbeing of patients in this group.

Good



### People with long term conditions

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

- Patients at the highest risk to unplanned hospital admissions were identified and care plans had been implemented to meet their health and care needs.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check that their health and medicines needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Nursing staff had lead roles in chronic disease management and had undertaken additional training.

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 living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Good



# Summary of findings

- The practice's uptake for the cervical screening programme was 78% compared with the CCG average of 80% and national average of 82%.

## 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 practice offered appointments outside of core working hours and provided online services to enable patients to book appointments, order repeat medicines and access some parts of their health records online.
- Health promotion and screening services reflected the health needs of this 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 held a register of patients living in vulnerable circumstances including known vulnerable adults, those who were housebound and patients with a learning disability.
- The practice had 50 patients recorded with a learning disability. All of these patients had received an annual health assessment. This performance was significantly higher than the national average uptake of around 50%.
- Staff adapted their processes to suit the needs of patients. For example, staff sent easy read letters of invitation to patients when this would help their understanding. They also planned more time when booking appointments.
- Staff had a good awareness of vulnerable patients in their care; they prioritised actions and regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

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).

Good



# Summary of findings

- Performance for poor mental indicators was better than local and national averages. For example, 95% of patients with enduring poor mental health had a recent comprehensive care plan in place compared with the CCG average of 86% and national average of 88%.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had an effective system in place to ensure that patients who had attended with symptoms with depression were followed up appropriately over time.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included comments made to us from patients and information gained from:

- The national GP patient survey published in January 2016. The survey invited 271 patients to submit their views on the practice, a total of 111 forms were returned. This gave a return rate of 41%.
- The practice had worked with the patient participation group (PPG) in both 2015 and 2016 to undertake in-house patient satisfaction surveys. One hundred and fifty patients had been surveyed in February 2016.

We spoke with one member of the patient participation group (PPG) 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.

In the national GP patient survey satisfaction levels were:

- Similar or higher than local and national averages in the areas of interactions with GPs and nurses.
- Lower than local and national averages in the areas of experience of making an appointment.

The practice's internal patient survey measured experiences of making an appointment and aligned with the national GP patient survey.

The feedback we received from patients about the practice was positive. Themes of positive feedback included the helpful, caring and compassionate nature of staff.

## Areas for improvement

### Action the service **MUST** take to improve

- Implement a recorded system to receive and act on alerts about medicines that may affect patients' safety.

### Action the service **SHOULD** take to improve

- Develop the significant event reporting process to maximise learning, including more detailed investigation and review.
- Install an Automated External Defibrillator (AED) in the practice as recommended in the 'Primary care – Quality Standards' published by the Resuscitation Council UK. Alternatively produce a written risk assessment to why an AED is not required.

- Ensure there is comprehensive clinical oversight if future plans to delegate the processing of and acting upon information about patients' care and treatment are implemented.
- Investigate the reasons for the higher than average attendance at A&E by registered patients.
- Consider wider use of the national GP patient survey in the practice systems for acting on patient feedback.

## Outstanding practice

The practice used an effective system to maximise the opportunity for patients to receive frequent checks on their wellbeing. Systems to monitor and contact patients to invite them for health assessments had been

developed over time. The practice consistently achieved higher than average outcomes in providing follow up care. For example, the practice had 50 patients recorded

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with a learning disability and they had provided all of the patients with an annual health check. This performance was twice the national average of uptake of the health assessments.

# Trent Vale Medical Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The team also included a GP specialist advisor and a practice manager specialist advisor.

## Background to Trent Vale Medical Practice

Trent Vale Medical Practice is registered with the Care Quality Commission (CQC) as a partnership provider.

The practice provides services via purpose built premises and at the time of our inspection 9,161 patients were registered to receive care and treatment. The partnership arrangements comprise of four partners holding a General Medical Services contract with NHS England. As part of our pre-inspection checks we established that the provider's registration with CQC needed to be varied to remove a partner who had retired and include a new partner. We have prompted the provider to do this.

The practice demographic is broadly similar to the national average although the practice has a 3% higher proportion of patients aged less than 18 years of age, when compared with the national average. The locality is one of less deprivation than the clinical commissioning group (CCG) area, although deprivation is higher than the national average. Geographically, the practice is less than one mile away from a major hospital serving the area.

The practice is open each weekday from 8am to 6pm. During these times the reception desk is staffed and remains open. The practice is contactable by telephone within core opening times with the exception of 1pm to

2pm and also a Thursday afternoon 1pm – 6pm. During lunchtimes an answer machine gives an emergency contact number to call and this is covered by a duty GP. After 1pm on Thursday incoming telephone calls are diverted to the locality out-of-hours provider. Extended hours appointments with both GPs and nurses are offered on Monday and Thursday until 7:45pm. The practice has opted out of providing cover to patients outside of normal working hours. These out-of-hours services are provided by Staffordshire Doctors Urgent Care Limited.

Staffing at the practice includes:

- Seven GPs (four female, three male).
- One registrar GP (currently female)
- Two practice nurses (female)
- Two healthcare assistants (female).

A practice manager and senior receptionist lead a team of data quality facilitators, administrative and reception staff.

## Why we carried out this inspection

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

# Detailed findings

## How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed the information we held about the practice. We also reviewed intelligence including nationally published data from sources including NHS Stoke on Trent Clinical Commissioning Group, Public Health England and the national GP patient survey.

During the inspection we visited the practice and spoke with members of staff including GPs, a registrar, the practice nursing team, the practice manager and administrative staff. We reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed records relating to the management of the practice.

We gathered feedback from patients by speaking with them directly and considering their views on comment cards left in the practice for two weeks before the inspection.

# Are services safe?

## Our findings

### Safe track record and learning

The practice had a transparent and widely used system to report and record significant events.

- All of the staff, both clinical and non-clinical, we spoke with knew the process for reporting significant events. Staff could recall recently reported events.
- The practice used an external system for reporting significant events involving others, external to the practice, to enable the wider sharing of learning.
- Significant events reported covered both clinical and administrative issues. There were a wide range of examples recorded and acted upon.
- In the previous year, the practice had recorded 25 significant events. All had been discussed at clinical meetings and where appropriate at wider practice staff meetings.

Whilst the system was well used and demonstrated an embedded clear culture of openness, we saw, at times, the recorded investigation lacked detail. Another less positive area was that significant events were closed on discussion, missing the opportunity for a review to see if the changes implemented as a result had worked.

The practice's process for acting on medicines alerts that may affect patient safety was not robust. Staff told us they received information, disseminated it and took action when needed. We looked at what action the practice had taken in relation to recent medicines alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Staff told us they had not received any of the recent alerts that we looked at. Shortly after of our inspection the practice identified that their subscription to the MHRA did not include medicines alerts. The practice took action by updating their subscription and auditing to see if they needed to review any patients who took the medicines concerned. In the 12 audits undertaken, five revealed no patients took the individual medicine. The remaining seven audits revealed no or minimal action was required. Any necessary action was being undertaken.

### Overview of safety systems and processes

The practice had a number of systems in place to minimise risks to patient safety.

- The practice had policies in place for safeguarding both children and vulnerable adults that were available to all staff. A GP was identified as the safeguarding lead within the practice. The staff we spoke with knew their individual responsibility to raise any concerns they had and were aware of the appropriate process to do this. All staff had received recognised training, although we saw the nurses had only received level one training. Nationally recognised guidance recommends a minimum of level two for qualified nursing staff. The members of nursing staff were knowledgeable on current safeguarding practice and had individually made appropriate referrals to the safeguarding professionals. The practice management team provided evidence to demonstrate they had arranged for the nursing staff to attend training to nationally recognised levels. Staff were made aware of both children and vulnerable adults with safeguarding concerns by computerised alerts on their records. We saw examples of when the practice had responded quickly to patients where concerns had been raised about their wellbeing.
- Chaperones were available when needed. All staff, who acted as chaperones, had received appropriate training, had a disclosure and barring services (DBS) check and knew their responsibilities when performing chaperone duties. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. The availability of chaperones was displayed in the practice waiting room.
- The practice was visibly clean and tidy and clinical areas had appropriate facilities to promote the implementation of current Infection Prevention and Control (IPC) guidance. IPC audits of the whole service had been undertaken annually, this included staff immunity to healthcare associated infections, premises suitability and staff training/knowledge.
- The practice followed their own procedures, which in all but one area reflected nationally recognised guidance and legislative requirements for the storage of medicines. This included a number of regular checks to ensure medicines were fit for use.
- The practice nursing team consisted of both practice nurses and healthcare assistants. The practice nurses used Patient Group Directions (PGDs) to allow them to administer medicines in line with legislation. A

# Are services safe?

healthcare assistant had received training to administer some medicines under specific circumstances. To enable this, the practice had a template to gain authorisation by a GP under a Patient Specific Direction (PSD). We saw prescriptions were securely stored. There was a system in place to track and monitor the use of computerised prescriptions but not personalised blank forms as suggested in guidance issued by NHS Protect. The practice submitted evidence after the inspection to demonstrate that a suitable system had been implemented.

- The practice prescribed medicines for patients with certain medical conditions under a shared care agreement between the practice and secondary care provider. The secondary care provider decided on the dosage of medicines and arranged patient monitoring, including blood function tests to look for any adverse side effects of the medicines. The practice responsibility was to prescribe the medicines. We looked at the system for oversight of the prescribing by reviewing four patient records. We saw that patients had received both the medicines and blood monitoring tests in line with hospital dosage instructions and nationally recognised guidance. However, repeat prescription cycles were set at intervals that were greater than the maximum recommended interval for blood monitoring. This could lead to a missed opportunity that a patient may receive the medicine, although they had not had the necessary blood monitoring. We spoke with the practice about this; they provided evidence to demonstrate that prescribing cycles had been reduced with an update in policy and procedure to reflect monitoring requirements.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The practice had medical indemnity insurance arrangements in place for all relevant staff.

## Monitoring safety and responding to risk

The practice had a number of measures in place to minimise and mitigate potential risks to patients, staff and visitors.

- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw that electrical equipment had passed their annual testing by three calendar weeks. The practice could demonstrate they had a date booked in the near future for the tests to be carried out.
- There was an up to date written legionella risk assessment in place. (Legionella is a bacterium which can contaminate water systems in buildings). The practice had been proactive in following up required any actions with the building landlord and was monitoring progress of them completing any required actions.
- Arrangements were in place for planning and monitoring the number and mix of staff required to meet patients' needs.
- The practice had up to date fire risk assessments and carried out regular fire drills. We did see that some firefighting equipment was overdue testing from March 2015.

## Arrangements to deal with emergencies and major incidents

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

- All staff had received recent annual update training in basic life support.
- The practice had emergency equipment which included oxygen and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).
- The practice did not have an automated external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm). We spoke with the practice about this and it had been an area of provision they had been exploring with the patient participation group (PPG). Staff felt their proximity to the local hospital and ambulance base meant that that historically, for them, emergency ambulance response times had been low. However, this had not been formally risk assessed or considered against nationally recognised guidance from the UK Resuscitation Council that suggested, within primary care, an AED should be immediately available. After the inspection the practice informed us that they planned to purchase an AED.

## Are services safe?

- Emergency medicines were held to treat a range of sudden illness that may occur within a general practice. All medicines were in date, stored securely and staff knew their location.
- An up to date business continuity plan detailed the practice response to unplanned events such as loss of

power or water system failure. The business continuity plan did not include alternative premises arrangements in the event of the practice being unsuitable or unavailable for use. The practice updated their business continuity plan after the inspection to include alternative premises arrangements.

# 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 used this information to deliver care and treatment that met patients' needs.
- Changes to guidelines were shared and discussed at both monthly provider clinical governance meetings and monthly journal learning clubs.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality 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:

- The practice achieved 99% of the total number of points available; this was higher than the national and clinical commissioning group (CCG) averages of 95%.

The system in use for maximising the opportunity for patients to receive a review of their condition was highly effective. The practice employed three clinical data facilitators, each with responsibility for clinical areas.

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

- Performance for poor mental health indicators was better than local and national averages. For example, 95% of patients with enduring poor mental health had a recent comprehensive care plan in place compared with the CCG average of 86% and national average of 88%. Clinical exception reporting was 5.3% compared with the CCG average of 9.6% and national average of 12.6%. 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 had received the treatment or medicine.

- Performance in the outcomes for patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD) were better than local and national averages. For example, 94% of patients had received a review of their condition in the previous 12 months, compare to the CCG average of 91% and national average of 90%. Clinical exception reporting was also better at 6% compared to the CCG and national average of 11%.
- Performance for diabetes related indicators was better than local and national averages. For example, 82% of patients with diabetes had received a recent blood test to indicate their longer term diabetic control was below the highest accepted level compared with the CCG average of 75% and national average of 78%. Clinical exception reporting was better at 6% compared with the CCG average of 9% and national average of 12%.
- The practice had 50 patients recorded with a learning disability. All of these patients had received an annual health assessment. This performance was significantly higher than the national average uptake of around 50%.
- The practice had a tracking system for patients who had presented with symptoms of depression. All of these patients were tracked to ensure their care and treatment had been followed up by a GP.

The practice participated in a number of schemes designed to improve care and outcomes for patients:

- The Quality Improvement Framework (QIF) is a local programme with the CCG area to improve the detection and management of long-term conditions.
- The practice participated in the avoiding unplanned admission enhanced service. Two per cent of patients, many with complex health or social needs, had individualised care plans in place to assess their health, care and social needs. Patients were discussed with other professionals at regular meetings held with the Integrated Locality Care Team (ILCT). If a patient was admitted to hospital their care needs were reassessed on discharge. The care plans were available in the patient's home to enable other health professionals who may be involved in their care to have comprehensive information about them.

# Are services effective?

## (for example, treatment is effective)

Data from the CCG QIF for 2014/15 showed that emergency admissions rates to hospital for patients with conditions where effective management and treatment may have prevented admission were 0.6% higher than the local average.

The practice used local and nationally recognised pathways for patients whose symptoms may have been suggestive of cancer. Data from 2014/15 from Public Health England showed that 60% of patients with a newly diagnosed cancer had been via a fast track referral method (commonly known as a two week wait). This was higher than the CCG average of 55% and national average of 48%. Earlier identification and appropriate referral is generally linked with better outcomes for patients in this group.

We looked at data from 2014/15 from the NHS Business Services Authority on the practice performance on prescribing medicines in four groups including hypnotics, antibiotics and anti-inflammatories. The practice performance placed them in line or better when compared with others.

Clinical audit was deeply embedded within the practice and encompassed a wide range of subjects including condition detection, effective medicines usage and health screening. The practice had completed over 25 audits in the previous year. Audits were repeated when relevant and some were constant cycle. The practice also reviewed and analysed all patient deaths to establish if there were any learning points for reflection. For example, if anything could have been done differently. With all audits, changes were made when necessary and learning was shared within the staff group at the practice journal club.

### Effective staffing

Staff at the practice were experienced and many had wider areas of expertise:

- GPs had specialist training in family planning, women's health, diabetes, clinical education, orthopaedics and neurology.
- Staff developed their skills to provide more services for patients. For example, the practice healthcare assistant had developed their skills to include administration of some medicines.

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through appraisals, and staff told us they felt supported.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness.

### Coordinating patient care and information sharing

We reviewed the system in use at the practice for receiving, handling and acting on information received about patients' wellbeing, care and treatment. Information was constantly received throughout each day and included blood test results, hospital discharge summaries, out-of-hours and A&E patient contact summaries. The volume of information received was high and the practice was fully up to date with the processing of the information.

Staff told us about, and we reviewed a trial system in place to allow non-clinical members of staff to, in certain circumstances, file normal blood results and patient communications that were recorded as requiring no action. The system was being trialled with total oversight of GPs with results and learning to be assessed in July 2016. We saw that if implemented as seen, the system could lead to increased risk of missed opportunities for some patients. For example, a hospital letter concerning a patient recently discharged from hospital did not state any actions in the written form, although closer analysis showed that there had been a suggested change to the patient's prescribed medicines. This letter would have been automatically filed as it did not contain a written instruction to perform the change. In relation to the blood tests, a non-clinical member of staff may file blood results that were stated as normal, without a clinician exploring further avenues of investigation or considering the stopping or variation an existing medicine. Of note a published report from a medical indemnity provider described the non-clinical staff filing of blood results as unsafe practice. We spoke with the practice, who assured us that the GPs had total oversight of the reviewing and filing of all interactions and would not introduce any system until they felt it was robust as was possible.

Staff worked together with other health and social care professionals to understand and meet the range and

# Are services effective?

## (for example, treatment is effective)

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.

The practice met with other professionals regularly to discuss patients approaching the end of their lives and those with complex health needs. Actions were clearly identified and prioritised in urgency using a Red, Amber and Green (RAG) rating system.

### 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. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Important decisions on when / when not to receive care, treatment or interventions were discussed with patients and when appropriate those close to them. This information was accurately recorded.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care, carers and those at risk of developing a long-term condition.

The practice's uptake for the cervical screening programme was 78% compared with the CCG average of 80% and national average of 82%. Clinical exception reporting in this area was 3% compared with the CCG and national averages of 6%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 97% to 100% and five year olds from 93% to 99%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Data from 2014, published by Public Health England, showed that the number of patients who engaged with national screening programmes was lower than local and national averages:

- 70% of eligible females aged 50-70 had attended screening to detect breast cancer compared to the CCG average of 75% and national average of 72%.
- 53% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer compared to the CCG average of 55% and national average of 58%.

In both outcomes the practice had conducted a recent audit and had followed up patients who had not engaged, highlighting the benefits and importance of participating in the programme.

Staff referred patients, where appropriate, for assistance with leading a healthier lifestyle including weight management and smoking cessation advice.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 17 completed cards, of which all were positive about the caring and compassionate nature of staff.

We spoke with one member of the patient participation group (PPG). They also told us they were 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. This included comments made to us from patients and information from the national GP patient survey published in January 2016. The survey invited 271 patients to submit their views on the practice, a total of 111 forms were returned. This gave a return rate of 41%.

The results from the GP national patient survey showed patients expressed positive satisfaction levels in relation to the experience of their last GP appointment. For example:

- 89% said that the GP was good at giving them enough time compared to the CCG and national averages of 87%.
- 96% had confidence in the last GP they saw or spoke with compared to the CCG and national averages of 95%.
- 90% said that the last GP they saw was good at listening to them compared with the CCG average of 88% and national average of 89%.

The results in the national patient survey regarding nurses similar or higher levels of satisfaction when compared locally and nationally:

- 92% said that the nurse was good at giving them enough time compared to the CCG average of 93% and national average of 92%.
- 96% said the practice nurse was good at listening to them with compared to the CCG average of 92% and national average of 91%.

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

Individual patient feedback we received from patients about involvement in their own care and treatment was positive, all patients felt involved in their own care and treatment.

The GP patient survey information we reviewed showed a comparable patient response to questions about their involvement in planning and making decisions about their care and treatment with GPs. The GP patient survey published in January 2016 showed;

- 81% said the last GP they saw was good at involving them about decisions about their care, which was the same as the CCG average and similar to the national average of 82%.
- 86% said the last GP they saw was good at explaining tests and treatments which was the same as the CCG and national averages.
- 90% said the last nurse they saw was good at involving them about decisions about their care compared to the CCG average of 87% and national average of 85%.
- 93% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 90%.

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

Patients and carers gave positive accounts of when they had received support to cope with care and treatment. We heard a number of positive experiences about the support and compassion they received.

The practice's computer system alerted staff if a patient was also a carer. The practice had identified 158 patients as carers (1.7% of the practice list). All registered carers had been all been contacted and offered an annual health check and seasonal flu vaccination.

## Are services caring?

If a patient experienced bereavement, practice staff told us that they were supported by a GP. The practice wrote to families to express their sympathy and invite further contact, listing wider organisations that may also have offered support.

# 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 offered evening appointments until 7:45pm on a Monday and Thursday.
- Online services for booking appointments and ordering repeat prescriptions were available.
- The practice had adapted their method of contacting some patients with a learning disability to invite them for a review of their health. When relevant, easy to read and pictorial letters were sent based on the individual comprehension of the patient.
- Staff used every opportunity to encourage patients to attend for condition reviews. The practice employed data quality facilitators to track progress in clinical areas which had led to higher than average patients engaging and attending conditions reviews.
- Same day appointments were available for children and those with serious medical conditions.
- Longer appointments were available dependent on patients need.
- Emergency admissions to hospital were reviewed and a GP contacted patients to review their care needs if required.
- There were disabled facilities and translation services available.

We reviewed the practice performance from 2014/15 in The Quality Improvement Framework (QIF) which is a local framework run by NHS Stoke on Trent CCG to improve the health outcomes of local people. The data demonstrated more of the practice's patients presented at hospital Accident and Emergency (A&E) departments when compared with the CCG average:

- The number of patients attending A&E, per 1,000, during GP opening hours was 2.3% higher than the CCG average. Performance over time (2012-2015) showed the rate of increase of GP opening hours patient A&E

attendance had increased by 1% compared to a CCG increase of 0.5%. Of note, the majority of the practice average increased rate had occurred over one year in 2014/15.

- The overall number of patients attending A&E, per 1,000, at any time was 1.7% higher than the CCG average. Performance over time (2012-2015) showed the rate of increase of anytime attendance had increased by 0.9% compared to a CCG increase of 0.6%.

The practice were aware of this and participated in the avoiding admissions enhanced service and a CCG initiative for a pharmacist to review patients with certain medical conditions who had attended A&E, although not been admitted to hospital. They also felt that their close proximity to A&E (less than one mile) was also a factor.

### Access to the service

The practice was open each weekday from 8am to 6pm. During these times the reception desk was staffed and remained open. The practice was accessible by telephone within core opening times with the exception of 1pm to 2pm and also a Thursday afternoon 1pm – 6pm. During lunchtimes an answer machine gave an emergency contact number to call. This was covered by a GP and after 1pm on Thursday incoming telephone calls were diverted to the locality out-of-hours provider. Extended hours appointments with both GPs and nurses were offered on Monday and Thursday until 7:45pm. When the practice was closed patients could access help by telephoning the practice, after which their call was transferred to the NHS 111 service for assistance.

Patients could book appointments in person, by telephone or online for those who had registered for this service. The availability of appointments was a mix of book on the day or routine book ahead. We saw that the practice had availability of routine appointments with practice nurses or healthcare assistants the next working day. The wait for a bookable GP appointment was three weeks, although patients could contact the practice at the opening time each morning for an on the day appointment. If a patient wanted an on the day appointment and none were available, a GP would telephone them to discuss their health needs and act accordingly.

We did not receive any negative feedback on appointments from patients. The practice was aware that the length of wait for booking an appointment ahead may be frustrating

# Are services responsive to people's needs?

## (for example, to feedback?)

for patients. A new GP had been recruited due to commence in September, exploration of extending the nursing staff capability to include patient triage was also underway..

Results from the national GP patient survey published in January 2016 showed mixed rates of patient satisfaction when compared to local and national averages:

- 64% of patients found it easy to contact the practice by telephone compared to the CCG average of 77% and national average of 73%.
- 88% of patients said the last appointment they made was convenient compared to the CCG average of 94% and national average of 92%.
- 50% of patients felt they did not have to wait too long to be seen compared to the CCG average of 60% and national average of 58%.
- 72% of patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.

In October 2015, the practice had conducted an internal patient satisfaction survey by distributing 150 questionnaires to patients. The survey mainly focussed on experience of making an appointment. Results were largely similar to the national GP patient survey. For example:

- 73% of patients found their last experience of making an appointment as convenient.
- 65% of patients found it easy to contact the practice by telephone.
- 71% of patients would be at least likely to recommend the practice to friends or family.

Following the patient survey the practice discussed the results with the PPG and implemented a number of changes. These included

- Varying the telephone system to ensure that telephone calls were answered more quickly.
- Advertising online services more proactively in an attempt to reduce call volume.
- Introducing posters within the practice and automated messages when calling to make patients aware of the reasons for increased demand.
- The practice had successfully recruited a GP to fill a vacant position.

### 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.

Information was available to help patients understand the complaints system and the complaints process was displayed on notice boards and a practice leaflet.

The practice had received 15 complaints in the last 12 months. We tracked two complaints and saw they had been acknowledged, investigated and responded to in line with the practice complaints policy. The practice analysed complaints for trends but found that there were none.

Complaints were discussed with the PPG, staff and at clinical meetings. Learning from complaints was evident from discussion with staff, although we saw learning outcomes were not always clearly recorded. When appropriate the practice issued an apology and explained how systems had been changed to limit the risk of reoccurrence.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

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

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

### Governance arrangements

The practice had a system in place to monitor and mitigate risks:

- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A comprehensive programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Governance was important to staff and relevant issues were evaluated and discussed within the delivery of services.

We saw a small number of areas of governance that needed more attention. For example, the action required after the issue of Drug Safety Alerts from the Medicines and Healthcare Regulatory Agency (MHRA). The practice was reflective and swift in response to these areas.

### Leadership and culture

The lead GP and practice manager were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

- When there were unexpected or unintended safety incidents, the practice gave affected people reasonable support, truthful information and a verbal and written apology.

Staff told us that they felt supported and able to make suggestions to how the practice provided services. All staff had received recent appraisals.

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). Staff encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

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

The practice had a patient participation group (PPG) who worked with staff to improve services. (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services). We spoke with one member of the PPG, they told us they met with the practice on a quarterly basis and the practice kept the members informed about relevant issues. The PPG was attempting to attract more members to become more representative of the patient demographic, although this had been challenging. Recent areas of exploration had been fund raising for a defibrillator and improvement in telephone access. The practice used the NHS Friends and Family Test and annual internal patient satisfaction surveys to discuss changes to surveys. We asked about the use of the national GP patient survey within the practice. Staff told us they did use the national survey, although some staff were not aware of this and it had not been clearly recorded. Fundamentally, the national GP patient survey results were similar to the practice's internal patient satisfaction survey.

The practice had away days for staff as part of team building and planning future services. Staff told us they felt able to provide feedback and discuss any issues in relation to the practice. All staff had received a recent appraisal and had a personal development plan.

### Continuous improvement

Staff told us that the practice had supported them to develop professionally. For example, the practice healthcare assistant had been developed from an

# Are services well-led?

Good 

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

apprenticeship to become a full time member of staff. They had extended their skillset to include phlebotomy (blood sample taking), spirometry and administration of some medicines under patient specific directions.

The practice supported registrars in their training to become qualified GPs. We spoke with a GP registrar currently attached to the practice, they were highly positive of the support given, and the skillset of staff, within the practice.

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      | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider did not operate an effective system to receive and take appropriate action on alerts issued by the Medicines and Healthcare Regulatory Agency about medicines.<br><br><b>12 (2) (g)</b> |
| Family planning services                 |  |
| Maternity and midwifery services         |  |
| Surgical procedures                      |  |
| Treatment of disease, disorder or injury |  |