Madeley Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (The practice was rated as Good at our previous inspection on 9 January 2015).

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Outstanding

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Madeley practice on 1 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learnt from them and improved their processes. However, we found risk assessments had not always been completed to mitigate some potential risks.
- The practice provided a holistic approach to assessing, planning and delivering care and treatment to patients. They introduced innovative approaches to care which they had shared locally and nationally to influence the delivery of care and treatment.
- The practice had developed innovative ways of reducing A&E attendance and unplanned admissions for older and vulnerable patients through the development of an elderly care facilitator (ECF).

Summary of findings

- The practice not only provided routine health promotion advise at patient annual health reviews but specifically targeted population groups to deliver effective and appropriate health promotion advise.
- The practice had developed a care template to support clinicians to recognise and diagnose sepsis in children.
- The practice had identified 235 patients as carers (3.4% of the practice list) through assessments carried out by the elderly care facilitator and self-referral forms available within the practice. The practice provided a weekly carer's clinic to advise them of the support and allowances available to them, and sign posted them to other areas of support.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The practice worked proactively with the voluntary sector and the patient participation group to meet the needs of their patients.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- GPs held leadership roles within the Clinical Commissioning Group (CCG). We saw that the knowledge and experiences they gained from these roles were embedded in the practice's culture.

We saw four areas of outstanding practice:

- The practice had developed innovative methods to reduce the number of visits to A&E or unplanned hospital admissions for older and vulnerable patients. A&E attendances for patients aged 75-84 years over a rolling 12 month period had fallen from 93 to 80 and unplanned hospital admission rates had fallen from 150 to 112. The practice had developed a door hanger to provide a concise summary of patients' details and needs if they were taken to hospital, led on the development and implementation of the elderly care facilitator (ECF) across the Newcastle-under-Lyme locality and were developing an extensivist model of care to provide earlier interventions. Their work on the care of older patients and a frailty tool had been published in a national medical journal.
- The practice offered a teenager clinic targeted at 15-16 year olds. Fifty-four per cent of teenagers invited to the clinic had taken up the offer to attend and were provided with an assessment of their health and mental health wellbeing. They were also offered sexual health advice. If a student was experiencing poor mental health they were supported by the practice and/or signposted to other services.
- The practice provided care and treatment for patients living in a secure unit for young adults experiencing poor mental health and/or a severe learning disability. The practice provided weekly ward rounds at the unit, 'flu immunisations and targeted health promotion groups, for example, smoking cessation.
- The practice was not only proactive in managing, monitoring and improving outcomes for its own patients but it shared its learning locally and nationally within primary care. For example, a practice nurse was a member of a university research group that had shared their findings with the Clinical Commissioning Group (CCG). They published their findings in a professional nursing journal regarding the benefits to the health economy in the use of tap water rather than sterile water for the cleansing of non-surgical wounds.

The area where the provider **must** make improvements as they are in breach of a regulation are:

- Ensure care and treatment is provided in a safe way to patients. In particular, review and complete a risk assessmentto demonstrate how risks to patients will be mitigated in the absence of recommended emergency medicines at the branch practice.

The areas where the provider **should** make improvements are:

- Complete a risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury.

Summary of findings

- Implement a system to track blank prescriptions used in printers throughout the practice.
- Update the practice's complaints leaflet and policy informing patients of how they can complain to NHS England. Update patient response letters of include details of the Parliamentary and Health Service Ombudsman.
- Review the Care Quality Commission (Registration) Regulations 2009 to support their understanding of incidents that are notifiable to the Care Quality Commission.

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

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients. In particular, review and complete a risk assessment to demonstrate how risks to patients will be mitigated in the absence of recommended emergency medicines at the branch practice.

Action the service SHOULD take to improve

- Complete a risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury.
- Implement a system to track blank prescriptions used in printers throughout the practice.
- Update the practice's complaints leaflet and policy informing patients of how they can complain to NHS England. Update patient response letters of include details of the Parliamentary and Health Service Ombudsman.
- Review the Care Quality Commission (Registration) Regulations 2009 to support their understanding of incidents that are notifiable to the Care Quality Commission.

Outstanding practice

We saw four areas of outstanding practice:

- The practice had developed innovative methods to reduce the number of visits to A&E or unplanned hospital admissions for older and vulnerable patients. A&E attendances for patients aged 75-84 years over a rolling 12 month period had fallen from 93 to 80 and unplanned hospital admission rates had fallen from 150 to 112. The practice had developed a door hanger to provide a concise summary of patients' details and needs if they were taken to hospital, led on the development and implementation of the elderly care facilitator (ECF) across the Newcastle-under-Lyme locality and were developing an extensivist model of care to provide earlier interventions. Their work on the care of older patients and a frailty tool had been published in a national medical journal.
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Madeley Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Madeley Practice

Madeley Practice is registered with the Care Quality Commission (CQC) as a partnership provider and is located in the village of Madeley, Cheshire. It is a rural practice providing care and treatment to 7,012 patients of all ages. The practice offers dispensing services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy. The practice holds a General Medical Services (GMS) contract. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice delivers services from two locations which we visited during our inspection:

- Madeley Practice is located at Moss Lane, Madeley, Crewe, Cheshire, CW3 9NQ.
- Baldwins Gate Surgery is located at 1 The Poplars, Tollgate Avenue, Newcastle-under- Lyme, Staffordshire, ST5 5DA.

The practice area is one of low deprivation when compared with the national and local Clinical Commissioning Group (CCG) area. Demographically the practice has a lower than average young population with 17% of patients being under 18 years old compared with CCG average of 18% and national average of 21%. Twenty-five per cent of the practice population is above 65 years which is higher than the CCG average of 21% and the national average of 17%. The percentage of patients with a long-standing health condition is 49% which is lower than the local CCG average of 57% and national average of 53%. The practice is a training practice for trainees to gain experience and professional qualifications in general practice and family medicine.

The practice staffing comprises of:

- Three GP partners (two male and one female)
- A salaried GP (male)
- Four GP Registrars (two male and two female)
- A specialist nurse practitioner, three practice nurses, a health care assistant and an elderly care facilitator.
- Four dispensary staff
- A practice manager, assistant practice manager and a trainee practice manager.
- Ten members of administrative staff working a range of hours.

Madeley practice is open between 8.30am and 6pm Monday to Friday and offers extended hours appointments on a Monday until 8.15pm. Appointments are from 9am to 11am every morning and 3pm to 5pm daily but may be extended depending on the daily demand for appointments. Baldwins Gate Surgery is open Monday to Friday from 9am until 12pm. Pre-bookable appointments can be booked up to six weeks in advance and urgent appointments are available for those that need them. Telephone consultations are also available to suit the needs of the patient. During the out-of-hours period services are provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

The practice offers a range of services for example, management of long term conditions, child development checks, contraceptive advice including the fitting of coils

and contraceptive implants, a counselling service and a warfarin monitoring service. Further details can be found by accessing the practice's website at www.madeleypractice.co.uk .

Requires improvement

Are services safe?

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing safe services. This was because:

- **A risk assessment to demonstrate how risks to patients will be mitigated in the absence of recommended emergency medicines at the branch practice had not been completed.**
- **A risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury had not been completed.**
- **A system to track blank prescriptions used in printers throughout the practice was not in place.**

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from the risk of abuse.

- The practice conducted safety risk assessments, for example for non-clinical staff who were waiting for relevant immunisations to protect them from health care acquired infections.
- The practice had safety policies and systems which were regularly reviewed and communicated to staff. Staff received safety information from the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and the risk of abuse. Staff took steps to protect patients from the risk of abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate recruitment
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Clinical staff who acted as chaperones were trained for the role and had received a DBS check. Staff we spoke with who chaperoned were aware of their role and responsibilities in protecting patients from the risk of abuse.
- There was an effective system to manage infection prevention and control. Annual infection control audits were completed by the practice's infection control lead. Where issues were identified an action plan and changes to procedures were implemented. For example, a new protocol for the cleaning of blood pressure cuffs had been implemented following the previous infection control audit. At our previous inspection in January 2015 we advised that the practice should introduce cleaning records to monitor that cleaning had been carried out daily in line with the cleaning schedule. At this inspection we saw that this had been done.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. However, a comprehensive asset register detailing all the equipment held at the practice was not in place. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. A staffing needs assessment had been carried out by the practice.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. We saw how the practice safely and effectively managed the urgent needs of a patient on the day of our inspection.
- Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. The practice had developed their own care template to support clinicians to recognise and diagnose sepsis in children.
- When there were changes to services or staff the practice assessed and monitored the impact on safety and made changes to mitigate any potential risks. For example, there was evidence of proactive succession planning to ensure the needs of the patients were met when a key member of staff left the practice. We saw that a 12 month training plan had been put in place to train and develop a new practice manager before the existing manager retired.

Requires improvement

Are services safe?

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. We saw that care records for patients with long term conditions, such as diabetes, contained self-management plans that were updated annually or sooner if needed, and they were shared with patients to keep them safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, the practice had a system in place for sharing information with the out of hours service for patients nearing the end of their life or if they had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) plan in place.

Safe and appropriate use of medicines

The practice had systems for the handling and dispensing of medicines:

- The systems for managing vaccines, medical gases and equipment minimised risks to patients.
- We found that GPs carried limited emergency medicines on home visits. The day after the inspection, the practice forwarded to us a risk assessment to demonstrate how they arrived at the decision to take a limited supply of medicines on home visits and the actions they took to mitigate potential risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Clinicians followed local microbiology protocols when prescribing antibiotics. There was evidence of actions taken to support good antimicrobial stewardship. For example, to ensure the safety and quality of care for patients with frequent urinary infections, an audit of patients receiving an antibiotic to prevent urinary tract infections had been carried out and medications reviewed if no longer appropriate to use. The practice ran monthly searches to ensure ongoing monitoring.
- Patients' health was monitored to ensure medicines were safely prescribed and followed up appropriately. The practice involved patients in regular reviews of their medicines. Patients with more than one long term condition were provided with one appointment to cover all of their needs.
- Arrangements for dispensing medicines at the main practice kept patients safe.
- At our previous inspection we advised that the practice should put measures in place to prevent the accidental interruption of the electricity supply to the vaccine fridges. At this inspection we saw that all fridge plugs were clearly marked to mitigate this risk.

However, we found areas where medicines were not appropriately managed:

- The practice held a range of medicines to cover medical emergencies at their main practice. However, we found the practice held a limited supply of emergency medicines at their branch practice. Some emergency medicines, for example an antibiotic for the treatment of bacterial meningitis or a medicine for the treatment of an epileptic seizure, were not available. A risk assessment to demonstrate how risks to patients would be mitigated in the absence of these medicines had not been completed.
- The practice had a system in place to store prescription pads securely and monitor their use. However, we saw that there was no lock on the door of one room where blank prescriptions used in printers were kept. The practice told us they would fit a lock to the printer in this room to ensure the security of the prescriptions stored there. The practice had a system in place to record receipt of blank prescriptions used in printers but there was no system in place to track their use throughout the practice.

Track record on safety

The practice had a good safety record.

- There were several comprehensive risk assessments in relation to safety issues. However, we saw that the practice used mercury blood pressure monitoring equipment. Mercury spillage kits were available for use in the event of a mercury spillage. A risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury had not been completed.

Requires improvement

Are services safe?

- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learnt and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. GPs and managers proactively supported them when they did so. Details of the procedures to follow were included in the staff induction pack.
- There were systems for reviewing and investigating when things went wrong. The practice learnt and shared lessons, identified themes and took action to improve safety in the practice. For example, to improve the security of electronic passwords staff were provided with information governance training and additional guidance was added to the practice's governance factsheet for staff which they all signed to say they had read.
- There was a system for receiving and acting on safety alerts. Safety alerts were a standard agenda item for clinical and practice meetings. Clinicians we spoke with told us of recent alerts they had received and the actions they had taken to ensure the safety of their patients. The practice learnt from external safety events as well as patient and medicine safety alerts.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as outstanding for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. The practice had adapted their care templates to include the need to manually assess the pulse of each patient they reviewed to identify any potential heart problems.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used technology and equipment to improve treatment and to support patients' independence. For example, ambulatory blood pressure monitoring and monitoring of blood clotting levels. The practice were developing skype consultations.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- Older patients who were frail or vulnerable received a full assessment of their needs by the elderly care facilitator (ECF). This role had been developed by the practice and rolled out to other practices within the Clinical Commissioning Group (CCG) as an example of best practice. They provided an average of 200 visits per year. When required they made referrals to therapists such as physiotherapy and occupational therapist. The ECF had worked with a local dentist to understand the dental needs of older patients. As a result, the ECF provided older people with up to date dental advice and had developed and distributed leaflets providing advice regarding dental and denture care for older patients.
- The practice had monitored and influenced changes to a nationally recognized assessment tool for frailty in older patients through research and the development of the role of the ECF. Their research into the frailty toolkit had been published in a national medical journal for the care of older patients.
- The practice had developed a door hanger for patients to hang on the inside of their front door. The door hanger contained a concise summary of their details and needs, such as next of kin details, who to contact in an emergency, GP contact details and the help needed with activities of daily living which could be taken with a patient if they attended A&E or had an unplanned hospital admission.
- The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice had been effective in reducing the number of Accident and Emergency (A&E) admissions and unplanned hospital admissions for older patients. Data collated by the CCG showed a continual downward trend in the number of patients aged 75-84 years taken to A&E or admitted for an unplanned hospital admission. For example, the number of A&E attendances over a rolling 12 month period had fallen from 93 to 80 and unplanned hospital admission rates had fallen from 150 to 112.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice offered an anti-coagulation clinic for patients receiving a medicine used in the prevention of blood clots. The effectiveness of the clinic was

monitored though a series of three monthly audits. The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results for 2016/17 showed that 83% of patients with a heart condition that causes an irregular heart rate and were at a moderate to high risk of stroke were treated with anti-coagulation therapy. This was comparable to the Clinical Commissioning Group (CCG) average of 87% and the national average of 88%.

- 80% of patients with asthma had received an asthma review in the preceding 12 months that included an assessment of asthma. This was higher than the CCG average of 77% and the national average of 76%. Their exception reporting rate of 4% was lower than the CCG average of 9% and national average of 8% meaning more patients had been included. Exception reporting is the removal of patients from QOF calculations where, for example, patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.
- 88% of patients with diabetes had a blood pressure reading (measured in the preceding 12 months) within recognised limits. This was higher than the CCG average of 80% and the national average of 78%. Their exception reporting rate of 5% was lower than the CCG and national averages of 9% meaning more patients had been included.
- The practice offered an ambulatory blood pressure home monitoring service.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Ninety-eight per cent of under two year olds had received the required vaccinations and the rate for five year olds ranged from 94% to 97%. These rates were above the 90% national expected coverage rate.
- The practice had developed their own care template to support clinicians to recognise and diagnose sepsis in children.
- The practice had worked with the local high school to help students to understand the needs of older people through a life story poster project and presentations.
- The practice offered a teenager clinic targeted at young adults aged 15-16 years old. Fifty-four per cent of teenagers invited to the clinic had taken up the offer to attend and were provided with an assessment of their health and mental health wellbeing. They were also offered sexual health advise. If a student was experiencing poor mental health they were supported by the practice and/or signposted to other services.

Working age people (including those recently retired and students):

- The practice's uptake for the cervical screening programme was 86%. This was slightly higher than the CCG average of 82% and the national average of 81%. Their exception reporting rate of 9% was comparable with the CCG average of 5% and the national average of 8%.
- 91% of patients aged 15 or over who were recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months. This was comparable with the CCG average of 85% and the national average of 90%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time, to protect them from the risk of meningitis or septicemia.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice provided sexual health advice and contraceptive services, such as contraceptive implants and coils, to their own patients and patients of surrounding practices.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose

circumstances may make them vulnerable. The practice had carried out completed audit cycles to monitor and improve the quality of the palliative care service provided to patients.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability or children with a child protection plan in place.
- The practice provided a weekly carer's clinic to advise them of the support and allowances available to them, and sign posted them to other areas of support. The practice had worked with Age UK to support carers to successfully access allowances available to support them in their caring role. Forty applications had been submitted and 39 were successful.

People experiencing poor mental health (including people with dementia):

- 96% of patients diagnosed with dementia had a care plan in place that had been reviewed in a face-to-face review in the preceding 12 months. This was higher than the CCG average of 85% and the national average of 84%. Their exception rate of 11% was slightly higher than the CCG average of 8% and the national average of 7%.
- 97% of patients with a diagnosed mental health disorder had a comprehensive, agreed care plan documented in their record, in the preceding 12 months. This was comparable with the CCG average of 91% and the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 97% of patients with a diagnosed mental health disorder had their alcohol consumption recorded in their notes in the preceding 12 months. This was comparable with the CCG average of 92% and national average of 91%. However, their exception reporting rate of 3% was lower than the CCG average of 9% and national average of 10% meaning more patients had been included.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, a review of patients receiving anti-coagulation therapy had been carried out to determine if any changes could be made to improve patients' blood clotting times. Where the need for improvements was identified, patients were called in for a formal review and appropriate changes to medication made.

Where appropriate, clinicians took part in local and national improvement initiatives. For example, a practice nurse was a member of the Critically Appraise Topics research group within Keele University. The groups aim was to identify, appraise and use best evidence to challenge traditional methods of delivering nursing care and treatment. Following a review of literature for the cleansing of non-surgical wounds with tap water rather than sterile water and a dressings audit, they were able to demonstrate the benefits to patients and the health economy. A report was written and submitted to the CCG to influence and change local practice and the findings were published in a well-known professional nursing journal in March 2016.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The most recent published results for 2016/17 showed the practice had achieved 100% of the total number of points available compared with the CCG average of 97% and national average of 96%. Their overall clinical exception reporting rate was 8% which was comparable with the CCG and national rates of 10%. Their exception reporting rate in each indicator was comparable with the CCG and national averages. Data collated by the CCG showed a continual downward trend in the number of patients taken to A&E or admitted for an unplanned hospital admission. For example, the number of A&E attendances for all age groups over a rolling 12 month period had fallen from 1576 to 1484 and unplanned hospital admission rates had fallen from 752 to 738.

We saw that the practice used information about care and treatment to make improvements. For example, the practice had carried out full cycle clinical audits in areas such as diagnosis of diabetes and palliative care to ensure that National Institute for Health and Care Excellence (NICE) best practice guidelines were followed and implemented.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, the ECF was being supported to complete a post graduate degree in medical science; frailty and integrated care, to enhance their knowledge in supporting frail patients.
- The practice provided staff with
- Staff were supported by training to develop within their roles.
- There was a clear approach through appraisal for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. For example, pain management for patients nearing the end of their life.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, teenagers experiencing poor mental health, patients with dementia and carers.
- The practice was effective in referring patients with possible cancer. Data from Public Health England showed that 55% of new cancer cases (among patients registered at the practice) were referred using the urgent two week wait referral pathway. This was comparable with the CCG average of 59% and the national average of 50%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, the practice used ambulatory home blood pressure monitoring and in house health promotion campaigns to raise awareness amongst patients.
- The practice supported national priorities and initiatives to improve the population's health. A member of the patient participation group (PPG) told us how the practice had worked with them to run a yearlong campaign on managing insomnia. They were also in discussion with the practice to deliver campaigns to address cancer screening, smoking and obesity.
- The practice not only provided routine health promotion advise at patients' annual health reviews but specifically targeted population groups to deliver effective and appropriate health promotion advise. For example; through the teenager clinics, health promotion campaigns within the practice, health promotion groups at a local secure unit for young people experiencing poor mental health or severe learning disability and the ECF who provided health promotion advice for older patients and patients with dementia.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The practice monitored the process for seeking consent through audit and training.

Outstanding ☆

Are services caring?

Our findings

We rated the practice, and all of the population groups, as outstanding for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Feedback from patients who used the practice was continually positive regarding the way they were cared for. All of the 23 patient Care Quality Commission comment cards we received were highly complementary about the service experienced. Patients told us staff were professional, caring, efficient, empathetic and friendly. They told us staff listened to them and provided exceptional care above and beyond what was expected. For example, phone calls from GPs when the practice had closed to ensure the needs of terminally ill patients were met.

The national GP patient survey results published in July 2017 showed the practice was performing above local Clinical Commissioning Group (CCG) and national averages in all of the survey indicators. Two hundred and twenty-five forms were distributed and 116 were returned. This represented 1.7% of the practice population. Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% of patients who responded said the GP was good at listening to them compared with the CCG average of 90% and national average of 89%.
- 95% of patients who responded said the GP gave them enough time compared to the CCG average of 89% and the national average of 86%.
- 96% of patients who responded said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 94% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 86%.
- 94% of patients who responded said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 96% of patients who responded said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and national average of 97%.
- 94% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.
- 94% of patients who responded said they found the receptionists at the practice helpful compared with the CCG and national averages of 87%.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language.
- Staff helped patients and their carers to find further information and access community and advocacy services. Patients told us that staff helped them to ask questions about their care and treatment. The practice also promoted the national 'It's OK To Ask' campaign on their practice website. The campaign encourages patients and carers to ask questions about their condition, what it means and the action they need to take.
- Practice staff had received dementia friends training to raise their awareness of how to support and involve patients with dementia in decisions about their care.

Outstanding ☆

Are services caring?

- Patients' emotional and social needs were seen as important as their physical needs. For example, the practice targeted assessment of the emotional and social needs of older and frail patients through holistic assessments by the elderly care facilitator (ECF), of young adults aged 15-16 years at a teenager clinic and carers at the carer's clinic.
- The practice worked in partnership with patients to deliver services to meet their needs. For example, to support patients to have blood tests carried out at the practice, the practice patient fund raised funds to partly fund the phlebotomy service. The practice had developed a door hanger for older patients that provided a quick and concise summary of their details to ensure that if they were taken to hospital, the hospital were aware of their needs. The practice provided weekly medication delivers and visits to rural, socially isolated patients. The practice gave examples of how they had used these visits to identify patients who required urgent medical treatment.
- The ECF proactively engaged with and worked alongside the voluntary sector to support patients who were socially isolated to be involved with local initiatives. For example, the ECF was a member of the Madeley locality action group. They encouraged carers to attend the 'Knit and Natter' action group established for older patients and patients with dementia.
- The practice offered creative alternatives to promote patient choice and involvement. For example, complementary therapies such as aromatherapy and reflexology alongside routine medical treatment of long term conditions. They supported a psychotherapist to provide emotional support for patients experiencing poor mental health.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 235 patients as carers (3.4% of the practice list) through assessments carried out by the elderly care facilitator and self-referral forms available within the practice.

- Patients identified as carers were invited to an annual health review with a GP. A carer's health review template had been developed to ensure the needs of carers were met.
- The ECF acted as a carers' champion to help to ensure that the various services supporting carers were coordinated and effective. They also provided a weekly carer's clinic at the practice to advise them of the support and allowances available to them, and sign posted them to other areas of support.
- The practice had worked with Age UK to support carers to successfully access allowances available to support them in their caring role.
- Carers were offered an annual 'flu vaccine.
- When the practice was aware that a patient registered with their practice had experienced bereavement, they were contacted by a GP. Bereaved patients were provided with advice on how access bereavement support services or local counselling services such as Dove.

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

- 93% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 93% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 96% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG and the national averages of 90%.
- 91% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.

Outstanding ☆

Are services caring?

- The practice complied with the Data Protection Act 1998.
- The practice had identified and trained dignity champions for each department within the practice. The ECF had rolled out and provided this training to other practices within the locality. A dignity champion we spoke with told us how they challenged any issues that may impact on patient dignity. There was also a system in place for staff to peer review, positively recognise and acknowledge staff approaches to maintaining patient dignity. Staff achievements in promoting patient's dignity were recognised at practice meetings.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as outstanding for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patients' needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended opening hours, online services such as repeat prescription requests, a teenager clinic and weekly medication deliveries and visits to rural socially isolated patients.
- The practice improved services where possible in response to unmet needs. For example, staff had received dementia friendly training, the practice provided unfunded sexual health advice services and bespoke holistic support for older and frail patients.
- To support patients to have blood tests carried out locally, the practice patient fund and the patient participation group partly funded a phlebotomy service at the practice.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, home visits were provided for housebound patients and telephone consultations for patients unable to access the practice within normal opening times.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice carried out awareness weeks and poster campaigns to support and sign post patients for additional support. The practice had carried out awareness weeks in relation to dementia, mental health and Parkinson's disease.

Older people:

- All patients had a named GP who supported them in the setting they lived, whether it was at home, in a care home or supported living.
- The practice implemented innovative ways of responding to the needs of older patients. They had worked with Age UK North Staffordshire to provide a domiciliary support package to support patients over 65 years of age with a physical or mental health disability to apply for attendance allowance support.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The ECF was a member of the Madeley and District Community Association and supported older patients to access services they provided. For example, the knit and natter group and the volunteer driver scheme.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team and the Integrated Local Care Team (ILCT), a team that included health and social care professionals, to discuss and manage the needs of patients with complex medical issues.
- The practice offered home visits for housebound patients with a long term condition.
- The practice and the patient participation group had worked together to raise awareness of the impact of insomnia and to sign post patients to appropriate support.
- The practice piloted complementary therapies such as aromatherapy and reflexology alongside routine medical treatment of long term conditions.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice offered annual teenager reviews which included a physical and mental health assessment and sexual health awareness.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were offered Monday 6.30pm until 8.15pm.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours. The practice was in the process of developing consultations by skype.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice provided care and treatment to patients living in a secure unit for young adults experiencing poor mental health and/or a severe learning disability. For example, the practice provided weekly ward rounds at the unit, 'flu immunisations and smoking cessation advice.
- The practice was proactive in identifying carers. The ECF offered a carer's clinic to support this population group and help to meet their needs.
- The practice worked with the district nursing team to support patients near the end of their life. They supported patients to die where they wished by providing frequent home visits and weekend visits or calls if needed.

People experiencing poor mental health (including people with dementia):

- Staff at the practice had received dementia friends training. They had provided this training to other GP practices in the locality and community sessions at the Madeley Centre. Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- All patients identified with dementia were provided with an assessment by the ECF and supported to access local groups such as music for memory sessions.
- The practice supported a trainee psychotherapist to provide emotional support for patients experiencing poor mental health.
- If a patient experiencing poor mental health moved out of the practice catchment area, they were supported to remain registered with the practice until their mental health was stable to ensure continuity of care.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use and the practice had systems in place to monitor and review improvements to access. For example, annual data from the national GP patient survey showed a consistent 69% satisfaction rate for patients getting through to the practice by phone. The practice installed a new telephone system and improved patient satisfaction to 81%.

Results from the July 2017 national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above local and national averages. This was supported by observations on the day of inspection and completed comment cards. Two hundred and twenty-five forms were distributed and 116 were returned. This represented 1.7% of the practice population.

- 80% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 81% of patients said they could get through easily to the practice by phone compared to the CCG average of 69% and the national average of 71%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 97% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 86% and the national average of 84%.
- 96% of patients said their last appointment was convenient compared with the CCG average of 84% and the national average of 81%.
- 92% of patients described their experience of making an appointment as good compared with the CCG average of 74% and the national average of 73%.
- 60% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 64% and the national average of 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available on the practice's website. There were complaints leaflets for patients to refer to but they were not readily accessible andthey did not inform patients that they could also complain to NHS England. The response letters sent to patients that we looked at did not inform patients of their right to complain to the Parliamentary and Health Service Ombudsman.
- The complaints policy and procedures were in line with recognised guidance. Two complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- The practice learnt lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Are services well-led?

Good

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

Our findings

We rated the practice, and all of the population groups, as good for providing well led services.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, succession planning for key members of staff who were leaving the practice.
- Leaders at all levels were visible and approachable. Staff we spoke with spoke highly of the support provided by the partners and practice manager.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The practice proactively supported the development of their staff, for example the elderly care facilitator was completing a post graduate degree in frailty.
- One GP partner was the locality lead for the Newcastle South and the quality lead for the Clinical Commissioning Group (CCG). We saw that the knowledge and experiences they gained from these roles were embedded in the practice's culture.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a strategy and supporting business plans to achieve priorities. There was clear evidence that the practice designed strategies and services around the needs of patients and they were effective. For example, a teenager clinic for students aged 15-16 years old who may be experiencing poor mental health in response to pressure from exams, the development of the role of the elderly care facilitator to support older and frail patients and a carer's clinic to support patients with caring responsibilities.
- The practice had developed its vision, values and strategy by collaborating with patients, staff and external partners. They had developed a mission statement: To provide high quality, safe, compassionate family based health care, as close to the patient's home as we can achieve with a focus on education and continuous reflection, learning and improvement.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. Initiatives developed within the practice had driven changes in the way that services were provided within the Clinical Commissioning Group. For example, the introduction and ongoing development of the elderly care facilitator, dementia training for staff and health clinics for carers.

Culture

The practice had a culture of high-quality sustainable care.

- We found there were high levels of staff satisfaction and staff stated they felt respected, supported and valued. Staff spoke with passion and enthusiasm about their role in caring and supporting patients. They told us that the management proactively supported and encouraged staff to access training and get involved with local initiatives to enhance their role.
- Leaders and managers acted on behaviour and performance which was inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. The practice was committed to developing their own staff to develop within the practice. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

Are services well-led?

Good

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

- Clinical staff were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally and described the practice as their family.
- The practice had signed up to the 'Freedom to Speak up Guardian' to support staff working in primary care to raise any concerns at the earliest opportunity.
- There were positive relationships between the management, staff and teams. There was a formal system in place for peers to recognise good practice within the team.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- Staff were clear of their roles and accountabilities in relation to safeguarding children and vulnerable adults and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. However, we found written risk assessments had not always been completed to mitigate potential risks and to provide clear guidance and support to staff.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through spot checks of their consultations, prescribing and referral decisions. Case studies of patient consultations were discussed at regular clinical meetings. Practice leaders had oversight of Medicines and Healthcare products Regulatory Agency (MHRA) alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in regular meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and shared at practice meetings or through appraisals.
- The practice used information technology systems to monitor and improve the quality of care. For example, home blood pressure monitoring.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- When we announced this inspection we identified that the practice had not submitted a statutory notification informing us about the absence of a registered individual for 28 or more consecutive days. The practice submitted a notification when we informed them of this legal requirement.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.

Are services well-led?

Good

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

- There was an active patient participation group (PPG) that meet alternate months. We spoke with a member of the PPG prior to our inspection. They told us the practice listened and acted on issues they raised. For example, improving patient confidentiality in the reception area at the branch practice.
- The practice and the PPG had participated in a local village information day to encourage patients to join the PPG, provide information about the services the practice provided and offer health promotion advise.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice.
- The practice used innovative and proactive methods to improve patient outcomes. For example, the practice had piloted in house complementary therapy and in house psychotherapy.
- The practice was not only proactive in managing, monitoring and improving outcomes for its own patients but it shared its learning locally and nationally to drive improvements within primary care. For example:
  - The practice's specialist nurse practitioner was a member of a university research group. The group had shared their findings with the Clinical Commissioning Group (CCG) and published its findings in a professional nursing journal regarding the benefits to the health economy in the use of tap water rather than sterile water for the cleansing of non-surgical wounds. The nurse had been awarded the Queen's Nurse Award for Outstanding Service for providing exceptional care to their patients and demonstrating continuing passion and enthusiasm for nursing.
  - The practice was the first practice within the Clinical Commissioning Group (CCG) to develop, implement and assess the effectiveness of the role of an elderly care facilitator (ECF) in providing holistic care for patients over 85 years old and those with dementia. As a result of this work ECFs have been employed within many other practices within the CCG. All practices within the Newcastle locality will have ECFs in place by 2018 with plans to roll this service out to practices within North Staffordshire and Stoke CCG.
  - The practice had influenced changes to a nationally recognised assessment tool for frailty in older patients through research and the development of the role of the ECF. Their research into the frailty had been published in a national medical journal.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. There was a formal system in place to encourage peer appraisal and reward.
- The practice was in the process of developing an extensivist service to determine the level of risk for patients over 75 years of age from unplanned hospital admissions. It aimed to develop a model of care to provide early intervention and reduce GP workload.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was improper and safe management of medicines. In particular: • A risk assessment had not been completed to demonstrate how risks to patients will be mitigated in the absence of recommended emergency medicines at the branch practice. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.