Middleport Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Middleport Medical Centre on 26 September 2017. Overall the practice is rated as good.

Middleport Medical Centre was previously registered with the Care Quality Commission (CQC) as a limited company with the provider, Network Healthcare Solutions. A change of provider took place in April 2016. The new provider is General Medical Services Limited. We carried out a comprehensive inspection of Middleport Medical Centre under the previous provider on 12 December 2014 and rated the practice as good. The report for the inspection carried out on 12 December 2014 can be found by selecting the 'all reports' link for Middleport Medical Centre on our website at www.cqc.org.uk.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- The practice had effectively worked with the pain management clinic to reduce and manage the high prescribing rate of two medicines that had the potential for misuse.
- Staff were aware of current evidence based guidance and had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- The practice maintained appropriate standards of cleanliness and hygiene.
- Appropriate recruitment checks had been undertaken prior to employment although satisfactory information about any physical or mental health conditions relevant to a person's ability to carry out their role had not been obtained for all staff.
- Results from the national GP patient survey published in July 2017 showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

Summary of findings

- Information about services and how to complain was available and the practice proactively acted on complaints posted on the national website, NHS Choices. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the management team.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

We saw one area of outstanding practice:

- The practice had effectively worked with the pain management clinic to reduce and manage the high prescribing rate of two medicines that had the potential for misuse.

The areas where the provider should make improvement are:

- Prior to employment, obtain satisfactory information about any physical or mental health conditions relevant to a person's ability to carry out their role.
- Update the cold chain policy to provide clear guidance for staff on the safe transportation and administration of vaccines to patients living in care homes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety. However, the cold chain policy did not provide clear guidance for staff on the safe transportation and administration of vaccines to patients living in care homes.
- The practice had proactively worked with the pain management clinic to reduce and manage the high prescribing rate of medicines that had the potential for misuse.
- Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice maintained appropriate standards of cleanliness and hygiene. However, cleaning schedules for the cleaning of clinical rooms were not in place.
- Appropriate recruitment checks had been undertaken prior to employment although satisfactory information about any physical or mental health conditions relevant to a person's ability to carry out their role had not been obtained for all staff.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) for the previous provider showed patient outcomes were at or above average compared to the national average however there was high exception reporting in some areas. The new provider was aware of these high exception reporting rates and had taken action to reduce them. Unverified QOF data for 2016/17 showed a continual downward trend in exception reporting by the new provider.
- Staff were aware of current evidence based guidance and had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Clinical audits demonstrated quality improvement.

Summary of findings

- There was evidence of appraisals for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved and when appropriate, information was shared with the out of hours service.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey published in July 2017 showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Through the comment cards we received, patients told us staff were caring, respectful and went the extra mile to be helpful. They told us they felt listened to by the GPs and the receptionists were very friendly.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- The results of the national patient survey and comment cards we received showed that patients found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from the examples we reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

- 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.
- There was a clear leadership structure and staff felt supported by the management team. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour.
- The management team encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from patients through surveys, the family and friends test and the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff were supported to attend training.
- The lead GP demonstrated a high level of involvement in the local health economy through their involvement with the local Clinical Commissioning Group and GP federation.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice followed up older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- The practice provided treatment and care to patients living in four large care homes. The practice held regular multidisciplinary team meetings with the care homes to meet the needs of patients living there.
- Older housebound patients were offered an annual home visit.
- The practice offered over 75 year old health checks.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, who had their blood pressure reading measured in the preceding 12 months and it was within recognised limits was 82%. This was comparable with the Clinical Commissioning Group (CCG) average of 77% and the national average of 78%.
- Patients with long term conditions such as diabetes and asthma were provided with a self-management plan and offered an annual review of their health. For those patients with the most complex needs, a GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Vulnerable patients with long term conditions were contacted within two days of post hospital discharge.

Summary of findings

Families, children and young people

Good

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

- The practice had a policy to follow up children who failed to attend for hospital appointments and children who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were high for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice held informal, weekly meetings with the health visitor to discuss children in need of additional support.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- The practice provided a 'Developing All Sexual Health' (DASH) service for young people aged 15-24 years. This included provision of and education relating to contraception, pregnancy testing and chlamydia screening.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations 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, telephone consultations.
- The practice was proactive in offering online services for booking GP appointments and ordering of repeat medication. They offered a full range of health promotion and screening that reflected the needs for this age group.
- The practice offered extended hours appointments until 8pm Monday to Wednesday for working aged patients who could not attend during normal opening hours.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

Summary of findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Patients with a learning disability were offered an annual health check and provided with longer appointments if needed.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice provided care and treatment for 60 patients with complex neurological problems living in a local care home and provided weekly ward rounds to review their care. All of these patients had a care plan in place which was reviewed regularly. The practice provided a dedicated telephone line for staff working at the home to ensure rapid access to clinical advice during an emergency.

People experiencing poor mental health (including people with dementia)

Good

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

- Data for the previous provider showed that 96% 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 higher than the CCG and national averages of 89%.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who failed to attend mental health reviews appointments.
- Data for the previous provider showed that 92% 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 comparable with the CCG average of 87% and the national average of 84%.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2017 showed the practice was performing above national averages. Three hundred and fifty-five forms were distributed and 87 were returned. This represented a return rate of 25%.

- 94% of patients described their overall experience of this GP practice as good compared with the Clinical Commissioning Group (CCG) average of 84% and the national average of 85%.
- 89% of patients described their experience of making an appointment as good compared with the CCG and national averages of 73%.
- 84% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and the national average of 77%.

Prior to our inspection we spoke with a member of the patient participation group (PPG). They told us they felt valued by the practice, the practice management were respectful of their views and listened to their suggestions. They told us they had quick and easy access to appointments and the staff were friendly, helpful and went out of their way to explain things.

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 48 comment cards of which 46 were highly positive about the standard of care received. Patients told us staff were caring, respectful and went the extra mile to be helpful. They told us they felt listened to by the GPs, there was good access to appointments and the receptionists were very friendly. Two comments were less positive but there was no common theme.

Data from the Friends and Families test for January to August 2017 showed that 201 out of 208 (97%) patients who responded were extremely likely or likely to recommend the practice to their friends and family.

Areas for improvement

Action the service SHOULD take to improve

- Prior to employment, obtain satisfactory information about any physical or mental health conditions relevant to a person's ability to carry out their role.
- Update the cold chain policy to provide clear guidance for staff on the safe transportation and administration of vaccines to patients living in care homes.

Outstanding practice

- The practice had effectively worked with the pain management clinic to reduce and manage the high prescribing rate of two medicines that had the potential for misuse.

Middleport Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector and included a GP specialist adviser.

Background to Middleport Medical Centre

Middleport Medical Centre is located in the city of Stoke-on-Trent and provides primary care services for patients in Middleport and the surrounding area. It also provides access to appointments at the provider's other practice, Shelton Primary Care Centre, Stoke-on-Trent. Middleport Medical Centre is registered with the Care Quality Commission (CQC) as a limited company. The practice holds an Alternative Personal Medical Services (APMS) contract with NHS England. An APMS contract is a locally agreed alternative to the standard General Medical Services (GMS) contract used when services are agreed locally with a practice which may include additional services beyond the standard contract.

The practice area is one of high deprivation when compared with the national and local Clinical Commissioning Group (CCG) area. At the time of our inspection the practice had around 5,505 patients. Demographically the practice has a higher than average young population with 24% under 18 years compared with CCG average of 22% and national average of 21% of which 9% are under 4 years of age compared with CCG and national averages of 6%. Eleven per cent of the practice population is above 65 years which is lower than the CCG and national averages of 17%. The percentage of patients with a long-standing health condition is 55% which is comparable with the local CCG average of 57% and national average of 54%. The practice is a training practice for medical and nursing students to gain experience in general practice and family medicine.

The practice staffing comprises of:

- A lead GP (male)
- Two salaried GPs (one male and one female)
- Two long term locum GPs (two male)
- An advanced nurse practitioner, two practice nurses and a health care assistant
- A business partner
- A business manager
- Six members of administrative staff working a range of hours.

The practice is open between 8am and 8pm Monday to Friday. Appointments are from 9am to 11.30am every morning and 3pm to 6pm daily. Telephone consultations are available at various times throughout the day. Extended practice hours to see the advanced nurse practitioner or a practice nurse are offered between 6pm and 7.30pm on Monday, Tuesday and Wednesday evenings. Pre-bookable appointments can be booked up to two weeks in advance and urgent appointments are available for those that need them. The practice has opted out of providing cover to patients in the out-of-hours period. During this time services are provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was

Detailed findings

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.

How we carried out this inspection

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. Prior to our inspection we spoke with a member of the patient participation group (PPG). We carried out an announced visit on 26 September 2017.

During our inspection we:

- Spoke with a range of staff including the lead GP, two salaried GPs, a practice nurse, a health care assistant, the business manager, the business partner and two receptionists.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the business manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The practice had recorded 20 significant events in the 12 months prior to our inspection. From the sample we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patient who became aggressive within the practice was referred into the violent and aggressive patient scheme provided by the practice.
- The practice also monitored trends in significant events and evaluated any action taken at clinical and team meetings.

The practice had a process in place to act on alerts that may affect patient safety, for example from the Medicines and Healthcare products Regulatory Agency (MHRA). Following an alert being received the practice checked to ensure that patients were not affected by the medicines or equipment involved and took appropriate action where required. We saw that MHRA alerts were a regular agenda item at the practice's monthly meetings.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding and staff we spoke with were aware to contact them if they had any safeguarding concerns. We saw that the practice was proactive in referring safeguarding concerns to the relevant agencies. We were shown an example of where a GP had reported their concerns to these agencies and the actions taken had resulted in a child being protected from the risk of abuse. The practice held weekly, informal meetings with the health visitor to discuss children of concern.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three.
- Alerts were placed on the electronic records of children and vulnerable adults where safeguarding concerns had been identified. There was a formal system in place for following up children who failed to attend for hospital appointments.
- Notices in clinical and consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place for the overall cleaning of the practice. Practice nurses told us they cleaned the clinical rooms but cleaning schedules were not in place to support this.
- A practice nurse was the infection prevention and control (IPC) clinical lead. There was an IPC protocol available on the practice's intranet and staff had

received up to date training. The IPC lead was due to attend additional training to support them in their role. Annual IPC audits were undertaken and action was taken to address any improvements identified as a result.

- Clinical staff had received appropriate immunisations against health care associated infections. Non-clinical staff had not received these immunisations and a risk assessment had not been completed to demonstrate how potential risks to staff and patients would be mitigated. Before the end of the inspection the practice completed a risk assessment to mitigate these risks.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicine audits and discussed prescribing issues at monthly clinical meetings to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms were securely stored.
- When a change of provider took place in April 2016, they identified there was a high prescribing rate of medicines that had the potential for misuse. We saw that over a period of time the practice had proactively worked with the pain management clinic to reduce and manage the prescribing of these medicines to reduce potential risks to patients. For example, the practice had identified 107 patients prescribed one of two medicines that had the potential for misuse. Over a 12 month period this had been reduced by 25%. At the time of our inspection the practice was continuing to support a further 15 patients on a reducing course of these medicines.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The health care assistant was trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.
- There was a system in place for the management of uncollected repeat prescriptions however on the day of our inspection we found a small number of prescriptions that were two to five months beyond their time of issue. The practice told us this role had been carried out by a member of staff who had recently left the practice and they would ensure their policy of monthly checks was carried out by an alternative member of staff.
- We saw that there was a system in place for monitoring the temperature of fridges used to store vaccines in line with manufactures' guidelines. We saw there were several occasions when the upper temperature range had been exceeded. The practice told us this was for a short period of time when they had received a new delivery of vaccines and the fridge door had been left open longer than was usual. The practice nurse told us that they checked that the temperature returned within normal limits however a second thermometer such as a data logger was not used to provide a method of cross-checking the accuracy of the temperature. Practice nurses provided flu immunisations to patients living in four care homes. We saw that the cold chain policy needed to be updated to provide clear guidance to staff on the safe transportation and administration of vaccines to patients living in care homes.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. However, satisfactory information about any physical or mental health conditions relevant to a person's ability to carry out their role had not been obtained prior to employment.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire evacuation drills. There were designated fire marshals within the practice.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.

Good

Are services safe?

- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. A large number of patients from a nearby practice had recently registered with the practice. The practice had a system in place to monitor the increased demand on the workforce and were reviewing plans to introduce additional skill mix such a pharmacist and a physician's associate.

Arrangements to deal with emergencies and major incidents

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

- Panic buttons were available in the consultation and treatment rooms which alerted staff to any emergency.
- The practice had emergency equipment which included an automated external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm), oxygen with adult and children's masks and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. All the staff received annual basic life support training.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nurses were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Minutes from monthly clinical meetings demonstrated there was a formal system in place to review and monitor NICE guidelines and to keep 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. The practice monitored that these guidelines were followed through a system of audits and searches.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The QOF results for the new provider were not available in the public domain at the time of our inspection. The 2015/16 QOF results for the previous provider showed the practice had achieved 100% of the total number of points available compared with the Clinical Commissioning Group (CCG) average of 96% and national average of 95%. However, the previous provider's overall clinical exception rate of 16% was higher than the CCG rate of 9% and the national rate of 10%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects

Data from 2015/16 showed:

- 86% of patients with asthma had received an asthma review in the preceding 12 months that included an assessment of their asthma using a recognised tool. This was higher than the CCG average of 77% and the national average of 76%. However, their exception reporting rate of 10% was higher than the CCG and national averages of 8%.
- 93% of patients with chronic obstructive pulmonary disease (COPD) had received a review including an assessment of breathlessness in the preceding 12 months. This was comparable with the CCG average of 89% and national average of 90%. However, their exception reporting rate of 17% was higher than the CCG average of 10% and the national average of 12%.
- The percentage of patients with diabetes, on the register, who had their blood pressure reading measured in the preceding 12 months and it was within recognised limits was 82%. This was comparable with the CCG average of 77% and the national average of 78%. However, their exception reporting rate of 21% was higher than the CCG average of 8% and national average of 9%.
- The percentage of patients with high blood pressure in whom the last blood pressure reading (measured in the preceding 12 months) was within recognised limits was 90%. This was higher than the CCG and national averages of 83%.
- 92% 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 comparable with the CCG average of 87% and the national average of 84%. Their exception rate of 0% was lower than the CCG average of 9% and the national average of 7%.
- 96% 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 higher than the CCG and national averages of 89%. However, their exception reporting rate of 27% was higher than the CCG average of 10% and national average of 13%.

The new provider was aware of these high exception reporting rates by the previous provider and had taken action to reduce them. The practice showed us unverified QOF data for 2016/17 which showed a continual downward trend in exception reporting. For example, in 2015/16, 121 patients had been exception reported, 33 patients in 2016/17 and none to date for 2017/18. Their overall unverified QOF achievements however remained comparable.

There was evidence of quality improvement including clinical audit. We looked at eight clinical audits completed in the last two years, all of these were completed audits

Good

Are services effective?

(for example, treatment is effective)

where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example, recent action taken as a result of audit had resulted in:

- improved monitoring on patients on high risk medicines.
- improved outcomes for patients with chronic obstructive pulmonary disease to prevent unplanned admissions to hospital and A&E.

Effective staffing

We found that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff we spoke with were positive about the induction support they had received.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, nursing staff had received training in managing long term conditions such as asthma and chronic obstructive pulmonary disease.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and vaccination and immunisation updates.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, role specific meetings such as monthly nursing meetings, mentoring and facilitation and support for revalidating GPs and nurses. Staff had received an appraisal within the last 12 months.
- Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We found that the practice shared relevant information with other services in a timely way. 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.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a three monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

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.

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 and Gillick competency.
  When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Two GPs carried out minor surgery at the practice such as joint injections. There was a policy for staff to refer to in obtaining consent for these patients and consent forms were also available.We saw that verbal consent for joint injections was recorded in patients' records.

Good

Are services effective?

(for example, treatment is effective)

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example, patients receiving end of life care, carers, those requiring advice on their diet and asylum seekers.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Data for the previous provider demonstrated that uptake rates for the vaccines given were comparable to CCG and national averages. For example, rates for the vaccines given to under two year olds ranged from 94% to 98% and five year olds from 86% to 91%.

Data for the previous provider showed that the practice's uptake for the cervical screening programme was 81%, which was comparable with the CCG average of 82% and the national average of 81%. The practice nurse showed us the systems and procedures they followed to ensure results were received for all samples sent for the cervical screening programme and followed up women who were referred as a result of abnormal results.

Data from the previous provider showed that the number of patients that attended national screening programmes for bowel and breast cancer were slightly below the CCG and national average. For example, 67% of females aged 50-70 years had been screened for breast cancer within six months of invitation was which was lower than the CCG average of 75% and the national average of 74%. Forty-six per cent of eligible persons aged 60-69 years had been screened for bowel cancer within six months of invitation which was lower than the CCG average of 50% and the national average of 56%.

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.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect. For example, we observed a carer was provided with an urgent appointment when they presented at the practice and explained they had had to leave the person they cared for with a neighbour.

We saw that curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations so conversations taking place in these rooms could not be overheard. Patients could be treated by a clinician of the same sex.

Forty six of the 48 patient Care Quality Commission comment cards we received were highly positive about the standard of care received. Patients told us staff were caring, respectful and went the extra mile to be helpful. They told us they felt listened to by the GPs, there was good access to appointments and the receptionists were very friendly. Two comments were less positive but there was no common theme.

Prior to our inspection we spoke with a member of the patient participation group (PPG). They told us they felt valued by the practice, the practice management were respectful of their views and listened to their suggestions. They told us they had quick and easy access to appointments and the staff were friendly, helpful and went out of their way to explain things.

Data from the Friends and Families test for January to August 2017 showed that 201 out of 208 (97%) patients who responded were extremely likely or likely to recommend the practice to their friends and family.

Results from the national GP patient survey published in July 2017 showed patients felt they were treated with compassion, dignity and respect. The practice was comparable with the clinical commissioning group (CCG) and national satisfaction scores on consultations with GPs and nurses. For example:

- 86% of patients said the GP was good at listening to them compared with the CCG average of 88% and the national average of 89%.
- 84% of patients said the GP gave them enough time compared to the CCG and national averages of 86%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and the national average of 86%.
- 95% of patients said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 88% of patients said the nurse gave them enough time compared with the CCG and national averages of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG and national averages of 97%.
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national averages of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised and older patients and those living in care homes that attended A&E or admitted to hospital were contacted within three days by a GP to ensure their care & further needs were met.

Results from the national GP patient survey published in July 2017 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 91% of patients 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%.

Good

Are services caring?

- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national averages of 82%.
- 95% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 92% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- There was a high number of asylum seekers registered with the practice. An interpretation service was available for patients who did not have English as a first language and alerts were placed on patients' records to highlight the need for an interpreter. There was a folder in the reception area informing patients this service was available. We saw that patients requiring the interpretation service were provided with double appointments.
- Patients with a hearing impairment were offered a sign language service during consultations.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services. There were leaflets available in the reception area informing patients of where they could access support following a bereavement.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 65 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them, for example the carer's hub and the carer's association. Older carers were offered timely and appropriate support and the practice provided weekly ward rounds to a large care home for patients with complex needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice provided treatment and care to patients living in four large care homes. The practice held regular multidisciplinary team meetings with the care homes to meet the needs of patients living there.
- Older housebound patients were offered an annual home visit.
- The practice offered over 75 year old health checks.
- Patients with long term conditions such as diabetes and asthma were provided with a self-management plan and offered an annual review of their health.
- Appointments were available outside of school hours for school aged children.
- The practice had an effective process to follow up children who failed to attend for hospital appointments.
- The practice held weekly, informal meetings with the health visitor to discuss children in need of additional support.
- The practice provided a 'Developing All Sexual Health' (DASH) service for young people aged 15-24 years. This included provision of and education relating to contraception, pregnancy testing and chlamydia screening.
- The practice offered extended hours appointments until 7.30pm Monday to Wednesday for working aged patients who could not attend during normal opening hours.
- The practice offered telephone consultations for working aged patients. They also provided online services for booking GP appointments and ordering of repeat medication.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice regularly worked with health and social care professionals and also the palliative care team to provide effective care to patients nearing the end of their lives and other vulnerable patients.
- Vulnerable patients were contacted by the practice within two days following a hospital discharge.
- Patients with a learning disability were offered an annual health check and provided with longer appointments if needed.
- The practice provided care and treatment for 60 patients with complex neurological problems living in a local care home and provided weekly ward rounds to review their care. All of these patients had a care plan in place which was reviewed regularly. The practice provided a dedicated telephone line for staff working at the home to ensure rapid access to clinical advice during an emergency.
- The practice was proactive in reviewing and reducing prescriptions for vulnerable patients who were prescribed potentially addictive medicines.
- The practice had a system in place to follow up patients who failed to attend mental health reviews appointments.

Access to the service

The practice was open between 8am and 8pm Monday to Friday. Appointments were from 9am to 11.30am every morning and 3pm to 6pm daily. Telephone consultations were available at various times throughout the day. Extended practice hours to see the advanced nurse practitioner or a practice nurse were offered between 6pm and 7.30pm on Monday, Tuesday and Wednesday evenings. Pre-bookable appointments could be booked up to two weeks in advance and urgent appointments were available for those that need them. The practice had opted out of providing cover to patients in the out-of-hours period. During this time services were provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

Results from the national GP patient survey published in July 2017 showed that patient's satisfaction with how they could access care and treatment was above local clinical commissioning group (CCG) and national averages.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 92% of patients were satisfied with the practice's opening hours compared with the CCG average of 79% and the national average of 76%.
- 84% of patients said they could get through easily to the practice by phone compared to the CCG average of 67% and the national average of 71%.
- 91% 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 83% and the national average of 84%.
- 94% of patients said their last appointment was convenient compared with the CCG and national averages of 81%.
- 89% of patients described their experience of making an appointment as good compared with the CCG and national averages of 73%.
- 80% of patients said they do not normally have to wait too long to be seen compared with the CCG and national averages of 58%.

Patient comment cards demonstrated that patients were able to get appointments when they needed them, there was good access to appointments and the receptionists were very helpful. Prior to our inspection we spoke with a member of the patient participation group (PPG). They told us they had quick and easy access to appointments.

The practice had a system to assess if a home visit was clinically necessary and the urgency of the need for medical attention. This assessment was carried out by the GP who made an informed decision and prioritised according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. The practice provided a dedicated telephone line for staff working at the care homes where they provided care and treatment to ensure rapid access to clinical advice during an emergency.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system on the practice's website and in their complaints leaflet.

The practice had recorded 15 complaints in the previous 12 months prior to our inspection. The practice also monitored comments on the national website, NHS Choices. We saw that the practice had included two complaints from the website to learn and drive improvements within the practice. We looked at three complaints received in the last 12 months and found they were satisfactorily handled, dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints, discussed at practice meetings, an analysis of trends carried out and action taken as a result to improve the quality of care. For example, several complaints were made regarding the attitude of a member of staff. This issue was addressed with the staff member who later left the practice.

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 provide a high standard of health care to their patient population and to continuously engage with patient representatives to improve services. They had a mission statement which stated they would provide a high quality of care to all patients in a timely manner whilst offering choice and involvement. Most staff we spoke with were aware of the vision and their roles and responsibilities in achieving it.

The practice had a clear five year strategy and supporting business plan which reflected the vision and values. We saw that it was regularly monitored and progress was recorded. The business plan focused on areas such as meeting the demands of a growing practice population, communication with staff, development of information technology within the practice and the introduction of additional skill mix.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, there was a GP lead for safeguarding and a practice nurse lead for infection control.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly. We saw that the cold chain policy needed to be updated to provide clear guidance to staff on the safe transportation and administration of vaccines to patients living in care homes.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of monthly practice meetings that demonstrated lessons had been learnt and shared with staff following significant events and complaints.

Leadership and culture

On the day of our inspection the business team demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Through conversations with staff and feedback comments from patients we found that they prioritised safe, high quality and compassionate care. Staff told us the GPs and business team were approachable and took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The business team encouraged a culture of openness and honesty. From the sample of significant events and complaints we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected patients reasonable support and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence. They also proactively monitored comments on the national website, NHS Choices, to improve their service.

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met informally with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us, and we saw minutes to confirm, that the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any

Are services well-led?

Good

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

issues at team meetings and felt confident and supported in doing so. Practice meeting minutes were methodical, structured and comprehensive. They were made available to all staff.

- Staff said they felt valued and supported by the management team. Salaried GPs told us they were well supported both clinically and educationally. Administrative and nursing staff spoke positively about the support from within the practice team. All staff were involved in discussions about how to run and develop the practice, and the business team encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met two-three monthly and told us that the practice responded to concerns that they raised. For example, the PPG had raised concerns regarding the dispensing of generic medicines rather than branded medicines by the local chemists. In response to this, the practice arranged for a local chemist to speak with the PPG to explain why this was safe to do.
- the NHS Friends and Family test, complaints and compliments received.
- staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management. Staff told us they felt involved and engaged to improve how the practice was run.
- the national website, NHS Choices.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The lead GP demonstrated a high level of involvement in the local health economy through their involvement with the local CCG and GP federation. The practice was becoming actively involved in the CCG locality, ANEW. Along with 16 other GP practices they were planning the design and develop of pathways of care in the development of a multispecialty, community-based new care model.