

# 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

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## Overall summary

### Letter from the Chief Inspector of General Practice

We inspected this service on 12 December 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found that the practice provided good care to all groups of its patient population.

Our key findings were:

- Patients received evidence based assessments and care and treatment was planned and delivered to promote a good quality of life.
- Staff treated patients with respect and kindness. Patients told us that staff were caring and compassionate.
- Services were planned and delivered to meet the needs of the patients. Patients were generally positive about the access to appointments.
- The leadership and management within the practice promoted an open and transparent culture. Staff felt able to contribute to the running of the service.

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

- Develop the criteria for significant events to ensure all significant occurrences (both positive and negative) are investigated and analysed to realise continuous improvement in the service
- Ensure that action taken following receipt of relevant national patient safety alerts is recorded and shared with staff
- Develop an action plan to demonstrate the effectiveness of actions taken to reduce the amount of antibiotic prescribing within the practice
- Develop and complete an on-going programme of clinical audits to evidence the quality of care provided and demonstrate improving patient outcomes
- Demonstrate and record evidence of effective joint working for patients with palliative care needs
- Ensure information about how to make a complaint is easily available for patients both on line and in reception and provide evidence that learning from complaints influences improvements in service delivery

# Summary of findings

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with the average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify that staff appraisals had been completed. Staff worked with multidisciplinary teams to improve outcomes for patients.

Good



### Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect and maintained confidentiality.

Good



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were generally satisfied with access to the service. The practice had recently recruited another GP to offer improved continuity of care. We saw that patients who required urgent appointments were seen or contacted by telephone on the same day.

Good



### Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice

Good



## Summary of findings

proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice was responsive to the needs of older people and offered home visits and rapid access appointments for those with enhanced needs.

Good



### People with long term conditions

The practice is rated as good for the care of people with long term conditions. Longer appointments and home visits were available when needed. All patients with a long term condition had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Good



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

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



### People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



# Summary of findings

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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Good



# Summary of findings

## What people who use the service say

We gathered the views of patients from the practice by looking at 14 CQC comment cards patients had filled in and by speaking in person with 16 patients, one of whom was involved with the Patient Participation Group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. Data available from the NHS England GP patient survey in 2013 showed that the practice scored amongst the worst nationally for patient satisfaction with the practice. The practice had taken steps to improve this position and had carried out further surveys of patients in March 2014 and

October 2014. These showed that there was an improvement in patients' overall experience of making an appointment and having confidence and trust in the GP and nurse.

Most patients we spoke with were positive about their experience of being patients at Middleport Medical Centre. They told us that they were treated with dignity and respect and the GPs, nurses and other staff were helpful and friendly. Three patients expressed some difficulty in accessing appointments and one patient said that they were not able to see a particular doctor. Four other patients said that they did not have a problem getting a same day appointment when required.

## Areas for improvement

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

- Develop the criteria for significant events to ensure all significant occurrences (both positive and negative) are investigated and analysed to realise continuous improvement in the service
- Ensure that action taken following receipt of relevant national patient safety alerts is recorded and shared with staff
- Develop an action plan to demonstrate the effectiveness of actions taken to reduce the amount of antibiotic prescribing within the practice
- Develop and complete an on-going programme of clinical audits to evidence the quality of care provided and demonstrate improving patient outcomes
- Demonstrate and record evidence of effective joint working for patients with palliative care needs
- Ensure information about how to make a complaint is easily available for patients both on line and in reception and provide evidence that learning from complaints influences improvements in service delivery

# Middleport Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a second CQC inspector, a practice manager specialist advisor and an Expert by Experience who had personal experience of using primary medical services.

## Background to Middleport Medical Centre

Network Healthcare Solutions provides primary medical services to over 30,000 registered patients from two GP Access Centres and eight GP practices in Staffordshire and Hertfordshire. Middleport Medical Centre is one of these practices.

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 has a Personal Medical Services (PMS) contract with NHS England. The service is responsible for providing primary care for 2243 patients and has a large number of patients who live in local nursing homes, 6% of the total patient list.

The practice has 3 part time GPs, (all male) and includes one salaried GP and two long standing locum GPs. There is a practice manager, a nurse practitioner, a practice nurse, a healthcare assistant, a senior receptionist and a reception team.

The practice does not provide an out of hours service to their own patients. Patients are provided with information about the local out of hours services based in Stoke-on-Trent which they can access by using the NHS 111 phone number.

The Care Quality Commission (CQC) has had no previous concerns about the practice.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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.

## How we carried out this inspection

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

## Detailed findings

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

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

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

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

Before carrying out our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 December 2014. During our inspection we spoke with a range of staff; one GP, one locum GP, one nurse practitioner, one healthcare assistant, the practice manager, the director of operations, the senior receptionist and a receptionist. We also spoke with the chair of the patient participation group (PPG), 16 patients who used the service and carers and/or family members. We reviewed 14 comment cards where patients and members of the public shared their views and experiences of the service.

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, national patient safety alerts as well as comments and complaints received from patients.

We reviewed safety records and minutes of meetings where these were discussed over a period of 12 months. This showed the practice had managed these consistently during the year and so could show evidence of a safe track record over the period.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events was a standing item on the practice meeting agenda and there was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff confirmed that they received alerts that were relevant to the care they were responsible for. However, there was no evidence that these were actioned when received. There was also no record to show that alerts were discussed at staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. The practice manager confirmed that this would be addressed immediately.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and reception staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and

children. They were also aware of their responsibilities and knew how to share information, to record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had a dedicated GP as the lead for safeguarding vulnerable adults and children. They had been trained and we saw that they had carried out the necessary training to enable them to fulfil this role such as an appropriate level in safeguarding children. Two staff members were not aware of who the lead for safeguarding was. Staff we spoke with confirmed that they would speak with the senior receptionist or practice manager if they had a safeguarding concern. The practice manager informed us that they would discuss safeguarding and the designated lead at the next staff meeting in January 2015.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the noticeboard and the screen in the waiting room. It was also available for patients' information in the consulting rooms. We saw that all nursing and reception staff had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

## Are services safe?

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the practice nurse had received appropriate training to administer vaccines. The healthcare assistant was booked on training to administer flu and B12 immunisations early in 2015. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role from the GPs as well as updates in the specific clinical areas of expertise for which they prescribed. The practice manager confirmed that plans were in place for the nurses within the Network Healthcare Solutions company to meet as peers on a quarterly basis to support each other.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

### Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw that all staff received infection prevention and control training. We saw evidence that the lead had begun to carry out audits. One completed audit seen had led to new guidance being developed for parents on how to clean the baby changing room after use.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings for examination couches were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example in relation to the safe disposal of sharps (needles).

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the vaccine fridge thermometer.

### Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

### Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Identified risks were included on a risk log and had been assessed and rated. However, we were not

## Are services safe?

able to evidence the mitigating actions that needed to be carried out in order to reduce and manage the risk. We saw that any risks were discussed at clinical meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

### **Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in the practice and all staff knew of their location. We saw that these were not locked away. This was addressed by the operations manager and the practice manager before the inspection was concluded. The emergency drugs included those for the treatment of cardiac arrest, anaphylaxis and

hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was identified and mitigating actions recorded to reduce and manage the risk. Risks identified included the loss of the computer system, incapacity of staff and loss of water supply. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training, that they practised annual fire drills and the fire alarm was tested weekly.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw that mitigating actions that had been put in place to manage these.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We saw that the lead GP was responsible for vulnerable patients. Practice nurses took the lead in specialist clinical areas such as hypertension (high blood pressure), diabetes and asthma. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice manager informed us that data from the local CCG of the practice's performance for antibiotic prescribing was higher than other practices. To address this, the practice had a pharmacy technician who came to the practice each week to help to monitor the level of antibiotic prescribing. We discussed the need for an action plan to demonstrate the effectiveness of actions taken to reduce the amount of antibiotic prescribing. The practice manager confirmed this would be actioned.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. We found that the information collected was not currently used to

support the practice to carry out clinical audits in addition to those completed for the Quality and Outcomes Framework (QOF). The QOF is a national performance measurement tool.

The practice were able to demonstrate that they had achieved 100% of the available points in the QOF for 2013/14 and this placed them top out the 10 practices in the Network Healthcare Solutions company. The practice also used the Quality and Improvement Framework (QIF) which is a Clinical Commissioning Group (CCG) improvement programme, as a tool to monitor their performance. The QIF is underpinned by a learning and development programme which includes workshops and master classes. The practice manager confirmed that the practice took part in these.

The practice also checked their performance against national screening programmes to monitor outcomes for patients. For example, all patients with diabetes had received an annual medication review, and the practice met all the minimum standards for QOF, for example in diabetes, asthma and chronic obstructive pulmonary disease (lung disease).

Apart from the QOF and QIF, the practice had not been involved in any other clinical audits in the last 12 months. This was mainly due to the practice not having a regular salaried GP until recently. The operations director confirmed that this was an area for development and Network Healthcare Solutions were committed to take a more active approach to demonstrate the quality of care provided and how they were improving patient outcomes. As part of this, they confirmed that a quality dashboard had been developed which would be used from January 2015 to enable Middleport Medical Practice to monitor and improve the quality of the service provided.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

# Are services effective?

## (for example, treatment is effective)

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and held multidisciplinary meetings which showed that the practice was proactively working to identify patients who should be included in this framework. However, we did not see evidence of how the care and support needs of patients and their families were jointly managed. The practice manager confirmed that minutes from the gold standards framework meetings would be improved to demonstrate effective joint working for patients at the end of their lives. This would take immediate effect.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area and in the period 2013 to 2014 they scored 100% of their available points in the QOF.

### Effective staffing

Practice staffing included medical, nursing, managerial and reception staff. We reviewed staff training records and saw that all staff were up to date with attending required courses such as annual basic life support. The lead GP was newly qualified in general practice and confirmed that support was provided if required by a lead GP at another practice close by within the Network Healthcare Solutions group. We saw that the GPs at Middleport Medical Centre were up to date with their yearly continuing professional development requirements and had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning and development needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example flu and other immunisations.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, for example those who saw patients with long-term

conditions such as asthma, chronic obstructive pulmonary disease (lung disease), diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service electronically or by post. We saw that specific staff had key responsibilities to pass on, read and act on any issues arising from communications with other care providers on the day they were received. The GP working in the practice on the day was responsible for the action required. We saw that this was a robust system. All staff we spoke with understood their roles and felt the system in place worked well.

The practice had a process in place to follow up patients discharged from hospital. Each patient was contacted after their discharge and were invited for a review by the GP and monitored as appropriate. We were told that the lead GP had plans to review all referrals to hospital in the near future to ensure that they were appropriate and met the relevant criteria for referrals.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children who were considered to be at risk of abuse. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff told us that they were able to contact the health visitor each day if needed. Weekly clinics were held by the health visitors and midwives at the practice and staff told us they worked closely with these other professionals particularly if they had a safeguarding concern about a child.

### Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider and accident and emergency (A&E) department to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made referrals to local hospital services through the Choose and Book system or directly to a surgeon of the patient's choice where possible. (The

# Are services effective?

## (for example, treatment is effective)

Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use. Staff told us that the lead GP was in the process of reviewing all referrals to make sure that they were all appropriate and that they met the criteria for non urgent referrals.

The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications such as those from hospital, to be saved in the system for future reference.

### Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, expressed consent (written or verbal) would be obtained for any procedure which carried a risk to the patient. This was documented in the electronic patient notes with a record of the relevant risks, benefits and possible complications of the procedure. The consent policy stated that an annual audit would be carried out to confirm consent was always sought and recorded in-line with the policy. We did not see evidence that this audit had been completed. The practice manager confirmed that the audit had not been completed.

The policy did not make specific reference on obtaining consent from patients who lacked capacity or the Mental Capacity Act 2005. However, it did include how the clinicians in the practice should take into account the views of carers who attended appointments with the patient.

When interviewed, staff were able to give examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

### Health promotion and prevention

We saw that there was a meeting held at the practice each month with the Clinical Commissioning Group and representatives from the 16 local general practices in the area. This meeting was held to discuss and share information about the needs of the local patient population and helped to focus on health promotion activity.

It was practice policy to offer a health check with the healthcare assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. Staff told us that they used their contact with patients to help to maintain or promote health and well being. For example, by offering opportunistic bowel screening and offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40-75.

The practice had numerous ways of identifying patients who needed additional support and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Also the practice actively offered smoking cessation clinics held by the healthcare assistant for patients who wished to stop smoking. This was a new service offering a twelve week course for a patient where the practice provided support, education and information to help patients give up smoking. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese or had hypertension (high blood pressure) and had commenced a 24 hour blood pressure monitoring facility.

The healthcare assistant told us that training had been arranged for them early 2015 to administer flu and specific immunisations. They also signposted patients who needed additional support to other organisations which included the Samaritans or a national domestic abuse lifeline.

There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. There was a named staff member responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with

# Are services effective?

(for example, treatment is effective)

current national guidance. Last year's performance for all immunisations was in line with the average for the Clinical Commissioning Group and there was a clear policy for following up non-attenders by a named staff member.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013, a satisfaction survey carried out by the practice in March 2014 and another smaller survey of 100 patients carried out by the practice and supported by the patient participation group (PPG) in October 2014. The data from the national patient survey showed the practice was rated 'among the worst' for patients who rated the practice as good or very good. This was based on 91 patient responses. This survey showed that the practice was below average for its satisfaction scores on consultations, with doctors with 68% of practice respondents saying the GP was good at listening to them and 70% saying the GP gave them enough time.

The practice was aware of this and had identified that the key areas for attention were the ability for patients to make appointments on the phone and the time spent with the GP. The practice had successfully recruited a part time female GP at the time of the inspection. Staff told us that this would help to reduce patients' perception of not having continuity of care and would also enable patients to build a doctor/patient relationship with their GP of choice.

As a result from the feedback from patients, the practice had set up an online facility for patients to register, book appointments, and order repeat medicines. The practice manager confirmed that these initiatives would help to reduce waiting times for patients to obtain their medicines and to enable those patients who needed to plan ahead the ability to pre book an appointment.

We spoke with the chair of the Patient Participation Group (PPG) who confirmed that they had a core group of members within the group and were keen to attract new members. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. They told us that they worked closely with the practice and felt that patient feedback on the service was listened to and acted upon.

Patients had completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 14 completed cards and the majority were positive about the service experienced. Two patients

said they felt the practice offered an excellent service and staff were very helpful and caring. Others said that staff treated them with dignity and respect. Four comments were less positive but there were no common themes to these. We also spoke with 16 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Three patients told us that they had problems getting through on the phone to make an appointment and could be waiting a long time to get through.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The layout of the waiting area and reception desk helped to prevent patients from overhearing potentially private conversations between other patients and reception staff. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

The practice operated a zero tolerance policy with regard to violence and abusive behaviour. Staff confirmed that referring to this had helped them diffuse potentially difficult situations.

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

The patient survey information we reviewed showed patients had mixed views about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 68% of practice respondents said the GP involved them in care decisions and 72% felt the GP was good at explaining treatment and results. Both these results were below the local Clinical Commissioning Group (CCG)

## Are services caring?

average. However, the results from the practice's own satisfaction survey carried out in March 2014 showed that most of the patients who responded (42 out of 50) said that they felt involved in making decisions about their care. Another patient satisfaction survey carried out by the practice in October 2014 showed the majority of patients who responded would recommend Middleport Medical Centre to someone who had recently moved to the area.

All of the patients that we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views except for one patient who said that they did not feel listened to.

Staff told us that translation services were available for patients who did not have English as a first language. We saw one of the reception staff offering this service for a patient during the inspection.

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

Patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required. Staff confirmed that they informed patients how to access a number of groups and organisations for emotional support, for example the Samaritans or a local charity such as Changes for those in mental distress. A range of leaflets were also available for patients in the practice on a wide range of support services.

Staff told us that if families had suffered a bereavement, the GP referred them to a local bereavement service DOVE if needed. Two patients we spoke with who had had a recent bereavement confirmed that the GP and other staff had been exceptionally supportive to them during a very difficult time.

The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address those needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the practice supported travellers by enabling them to use the practice address to register for NHS services.

The practice population was mainly white British with a smaller number of Asian and Eastern European patients. The practice catered for other different languages and used online and telephone translation services. Double appointments were also available for those who needed to have an interpreter with them.

The practice provided equality and diversity training through e-learning. Two staff we spoke with confirmed that they had completed the equality and diversity training in the last 18 months. Records seen supported this.

The premises were suitable to meet the needs of people with disabilities. The building was purpose built in 2010 and had easy access for all patients with mobility issues, wheelchairs and pushchairs. The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. There was lift access to the first floor for staff if required. The practice had sufficient room for turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and

allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

### Access to the service

Appointments were available from 8am to 8pm on weekdays. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Three patients we spoke with told us that they had difficulty getting through on the telephone to make an appointment. The practice was aware of access difficulties for some patients and had taken steps to improve the situation by offering an online booking facility and telephone consultations where appropriate.

The practice provided extended opening hours each weekday until 8pm where appointments for specific clinics were available. This was particularly useful to patients with work commitments. This was confirmed by two patients we spoke with who told us that this meant that they did not have to lose time at work for medical appointments. The practice offered an online booking system and sent text message reminders for appointments and test results.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in

# Are services responsive to people's needs?

(for example, to feedback?)

line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients know how to make a complaint on the practice website and was included under 'practice policies' on the practice website. We did not see a copy of the practice's complaints policy in the waiting area. Staff told us that patients could

ask at reception for a complaints leaflet. All of the patients we spoke with told us that they did not know how to make a complaint. However, they also said that they had not ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. We saw that the practice promoted openness and transparency when dealing with complaints. However the practice had not followed their own policy to demonstrate that lessons had been learned from these complaints and that learning was shared routinely with staff.h

# 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 vision to 'deliver high quality clinical services to the communities we serve'. The practice had a commitment to maintain and develop the general practice services at Middleport Medical Centre. It had a strategy to recruit salaried GPs and to train and develop existing staff to ensure a greater consistency of care was provided to patients. The practice was currently in discussion with NHS England and the Clinical Commissioning Group (CCG) to take this strategy forward.

We saw that staff had discussed the vision and strategy at regular practice meetings. We spoke with four members of staff including the director of operations who were knowledgeable about the plans to take forward the strategy and their responsibilities in relation to this.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures and saw that they had been reviewed annually and were up to date. Staff we spoke with were clear about how to access the policies and told us how they were kept up to date with any changes to them.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP lead for safeguarding vulnerable patients. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF is a national performance measurement tool. The QOF data for this practice showed it was performing in line with national standards. The practice also used the Quality and Improvement Framework (QIF) which was a programme to encourage general practices in the local area to improve outcomes for patients. We saw that QOF and QIF data was regularly discussed at monthly clinical team meetings and action taken to maintain or improve outcomes.

The practice manager told us about a peer review system they took part in with other local GP practices within Network Healthcare Solutions group. We looked at information which showed that the practices measured their service against each other and identified areas for improvement. We saw that the practice discussed their performance at regular meetings where clinical staff also attended.

The practice did not have an on-going programme of clinical audits to monitor quality and systems (other than those required for the QOF and QIF). This would enable the practice to determine the possible areas for improvement within the service and demonstrate the quality of care provided. We discussed this with the practice manager and the lead GP who told us that they had recognised this was an area for improvement and would be addressed now that the practice had two salaried GPs in post.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

### Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice where they felt happy to raise issues at team meetings and were listened to.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, an induction policy, sickness policy and training policy which were in place to support staff. We saw that all policies and procedures were available electronically and were available to all staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and saw that a small number of patients had difficulty accessing appointments via the telephone. We saw as a result of this that the practice had introduced an online booking system. We saw that the practice had carried out a small survey with patients over a three week period in October 2014. This demonstrated an improvement in patient satisfaction across most areas.

# Are services well-led?

Good 

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

The practice had a patient participation group (PPG) which had carried out a patient satisfaction survey in conjunction with the practice. We saw the results of this survey and the actions that were taken by the practice as a result of this. The results from this survey were available on the practice website. We spoke with the chair of the PPG who told us that they felt supported by the practice and had plans to conduct another survey later in the year.

The practice gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training to provide specific vaccinations, for example flu and this had been arranged to take place in April 2015. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

## Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that annual appraisals had taken place which had included identifying individual training needs. Staff told us that the practice was very supportive of training and that they were encouraged to remain up to date with current guidance and best practice.

The practice had completed reviews of significant events and shared them with staff at meetings to ensure the practice improved outcomes for patients. We saw an audit summary of the significant events recorded at the practice within the last twelve months. A significant event audit (SEA) is when individual cases in which there has been a significant occurrence are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care and to indicate changes that might lead to future improvements. Significant events can be very wide-ranging and can reflect good as well as bad practice and do not necessarily involve an undesirable outcome for the patient.