Dr McGowan and Partners

Quality Report

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

Ratings

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 Dr McGowan and Partners on 15 June 2016. Overall the practice is rated as good.

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 took the opportunities available to them to improve the range of services available to patients.
- Staff were experienced, engaged, confident and well trained for their role.
- Risks to patients were thoroughly assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP 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. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw an outstanding feature of the practice:

The practice had taken action following patient and staff feedback about high patient demand for appointments. A GP provided daily cover as a 'floor walker' each morning.

Summary of findings

This was to directly support staff to flow patients to the most suitable appointment for their needs. Patients had the benefit of, when appropriate, being able to talk with the GP directly to discuss their issue. The practice was able to demonstrate that the GP was able to resolve around 75% of issues at the time of the call. Previously this would have resulted in an on the day appointment being taken. Commonly the GP was dealing with in excess of 20 patient contacts each morning as a floor walker.

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.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Risks to patients had been thoroughly assessed and the processes in place promoted a safe working culture.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- There was a multi-skilled senior clinical team including GPs, advanced nurse practitioners and a pharmacist and all staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs

Are services caring?

Good

The practice is rated as good for providing caring services.

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

- The practice had identified a high number of patients who were carers. A total of 2.8% of patients were identified as carers and the practice was working towards further improving services for carers.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- The number of patients attending A&E during GP opening hours was lower than the clinical commissioning group (CCG) average.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed 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.

- 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.
- Leadership within the practice was visible and decisive. The practice had evolved in challenging circumstances and continued to look to the future.
- There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken

Summary of findings

- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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.

- Demographically the practice had more patients aged over 65 years of age than other local practices. Data showed that 20% of patients were aged 65 and over, compared to the clinical commissioning group and national averages of 17%.
- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice reviewed all unplanned admissions to hospital, although closely focused on those aged over 65. An advanced nurse practitioner assessed the circumstances for admission and when necessary contacted patients to establish if any additional support or intervention was required.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Good

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

- There was a team approach to reviewing the care needs of patients with long-term conditions.
- The practice had recruited a clinical pharmacist on a full time basis in 2014 with a primary focus on improving the outcomes for patients with long-term conditions including Chronic Obstructive Pulmonary Disease (COPD).
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

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 the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Appointments were available from 7:30am each morning and one evening each week.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

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.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- 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.

Summary of findings

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).

- 92% of patients with dementia had a face to face review of their condition in the last 12 months. This was higher than the clinical commissioning group (CCG) average of 85% and national average of 84%. Clinical exception reporting was 3% compared to the CCG and national averages of 8%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

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

- The national GP patient survey published in January 2016. The survey invited 265 patients to submit their views on the practice, a total of 106 forms were returned. This gave a return rate of 38%.
- We received two statements from members of the patient participation group (PPG) and invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 26 completed cards.

In the national GP survey, patient satisfaction was positive in most areas although lower than average for access to the practice by telephone:

- 84% described their overall experience of the GP practice as good compared to the clinical commissioning group (CCG) average of 87% and national average of 85%.
- 84% said the GP was good at treating them with care or concern compared to the CCG average of 84% and national average of 85%.
- 87% said the GP was good at giving them enough time which was the same as the CCG and national averages.
- 93% said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 90% said the nurse was good at treating them with care or concern compared to the CCG average of 92% and national average of 91%.
- 84% found receptionists helpful compared to the CCG average and national averages of 87%. Sixty-nine per cent of patients found it easy to contact the practice by telephone compared to the CCG average of 77% and national average of 73%. The practice was aware of this and had an action plan in place to review and improve performance.
- 95% of patients said the last appointment they made was convenient compared to the CCG average of 94% and national average of 92%.
- 75% of patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 79% of patients said they were able to get a convenient appointment the last time they tried compared to the CCG and national averages of 76%.
- 69% of patients found it easy to contact the practice by telephone compared to the CCG average of 77% and national average of 73%.

The comments we received from patients were positive about their care and treatment and mostly positive about access to the practice.

Outstanding practice

We saw an outstanding feature of the practice:

- The practice had taken action following patient and staff feedback about high patient demand for appointments. A GP provided daily cover as a 'floor walker' each morning. This was to directly support staff to flow patients to the most suitable appointment for their needs. Patients had the benefit of, when appropriate, being able to talk with the GP directly to discuss their issue. The practice was able to demonstrate that the GP was able to resolve around 75% of issues at the time of the call. Previously this would have resulted in an on the day appointment being taken. Commonly the GP was dealing with in excess of 20 patient contacts each morning as a floor walker.

Dr McGowan and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr McGowan and Partners

Dr McGowan and Partners is registered with the CQC as a partnership provider. The provider operates two practices within the NHS Stoke on Trent Clinical Commissioning Group (CCG) area. This inspection focussed solely on the services provided from Moorcroft Medical Centre.

The practice operates out of purpose built premises close to Hanley city centre. The practice has patients from all age groups receiving care and treatment, although of note there are more patients aged over 65 when compared with local and national levels:

- 20% of patients are aged 65 and over compared to the clinical commissioning group and national averages of 17%.
- The practice area is more deprived when compared with both local and national averages.
- Income deprivation for older people is worse within the practice area (27% of patients meet this threshold compared to the CCG average of 20% and national average of 16%).
- The practice has identified more patients with long-term conditions than local and national averages.

These factors can influence the demand for health services on a general practice.

At the time of our inspection the practice had a stable list size of around 8,000 patients.

Staff work at both practices run by the provider. Although as a guide the following staff are normally based at Moorcroft Medical Centre :

- Six GPs (two female and four male).
- Two female advanced nurse practitioners.
- A male prescribing pharmacist.
- Three practice nurses (two female, one male) and one female healthcare assistant.
- The administrative team is led by a managing partner, practice manager and other managers totalling over 30 staff.

The practice have their opening times displayed within the premises and detailed on their website:

- The reception is open 7:30am to 6pm Monday, Wednesday and Friday, 7:30am to 7:45pm on Tuesday and 7:30am to 1pm on Thursday.
- Telephone access for routine appointments and queries is on Monday, Wednesday and Friday 8am to 12pm then 2pm to 6pm, Tuesday 8am to 11:30am then 2:30pm to 6pm and Thursday 8am to 1pm. Outside of these hours each weekday patients can telephone an alternative telephone number for urgent assistance.
- In line with local arrangements the practice closes at 1pm each Thursday. Patients can access assistance at this time and the out-of-hours service by telephoning the practice telephone number from where their call is transferred to the local out-of-hours provider.

Detailed findings

The practice has opted out of providing out-of-hours services to their patients, these services are provided by Staffordshire Doctors Urgent Care.

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 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. We carried out an announced visit on 15 June 2016.

During our visit we:

- Spoke with a range of staff (including GPs, advanced nurse practitioners, a pharmacist, a managing partner and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised 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.

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 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

The practice operated an effective system to report and record significant events.

- A safe track record over time was clearly evident; the practice had been recording significant events and had made changes to the way they worked for over 10 years.
- Staff were open and transparent about raising, discussing and learning from significant events. All of the staff we spoke with knew the process to raise significant events and could recall recent occurrences.
- Significant events were reviewed over time for trends and were discussed at meetings for shared learning within the practice.
- The practice shared learning across both of their sites and if an incident involved an external party, the findings were recorded on an external incident reporting system.
- In the previous year 11 significant events had been recorded.

When needed, the practice changed the way that they worked to minimise the chance of reoccurrence of incidents. For example, following an emergency situation, guidelines had been developed for staff to advise them of the information required by the ambulance service. This was to ensure the required information was available at the time of calling for an ambulance to prevent a possible delay.

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). Information was shared with staff and when needed action had been taken to minimise risks to patients from medicines and equipment.

A culture to encourage duty of candour was evident through the significant event reporting process. Duty of candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Overview of safety systems and processes

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

- Staff were knowledgeable about their individual responsibility to safeguard those at risk of increased harm including children and vulnerable adults. We saw examples of when concerns had been identified, importantly they had been acted upon. The practice had policies in place for safeguarding both children and vulnerable adults that were available to all staff. All staff had received role appropriate training to nationally recognised standards, for example, GPs had level three training. A GP was identified as the safeguarding lead within the practice. Staff were made aware of both children and vulnerable adults with safeguarding concerns by computerised alerts on their records.
- A notice in the waiting room 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 checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice was visibly clean and tidy and clinical areas had appropriate facilities to promote the implementation of current Infection Prevention and Control (IPC) guidance. IPC audits of the whole service had been undertaken annually, this included staff immunity to healthcare associated infections, premises suitability and staff training/knowledge. The practice had a lead IPC staff member and frequent spot audits had been carried out by members of the management team to ensure scheduled cleaning had taken place and the practice was complying with their own comprehensive policies and schedules.
- The practice followed their own procedures, which reflected nationally recognised guidance and legislative requirements for the storage of medicines. This included a number of regular checks to ensure medicines were fit for use. The practice nursing team prescribed or administered medicines within the boundaries of their practice. The advanced nurse practitioners and pharmacist were all independent prescribers and had undertaken nationally recognised training for their role.

Good

Are services safe?

Practice nurses used Patient Group Directions (PGDs) to allow them to administer medicines in line with legislation. Blank prescriptions were securely stored and there were systems in place to monitor their use

- Patients who took medicines that required close monitoring for side effects had their care and treatment shared between the practice and hospital. The hospital organised assessment and monitoring of the condition and the practice prescribed the medicines required. The practice had proactively mitigated the risks of missed opportunities from patients receiving the medicines without having had the necessary monitoring.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. The practice had medical indemnity insurance arrangements in place for all relevant staff.

Monitoring risks to patients

Risks to patients were assessed and well managed. The management team had a comprehensive process of recording and follow up on known risks. We saw that regular action had been taken to mitigate risks.

- The practice had up to date fire risk assessments and carried out regular fire drills.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs.
- The practice performed regular water temperature testing and flushing of water lines and had a written risk assessment for Legionella. (Legionella is a bacterium which can contaminate water systems in buildings).

Arrangements to deal with emergencies and major incidents

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

- All clinical and reception areas had the facility to summon help in an emergency.
- All staff had received recent annual update training in basic life support.
- The practice had emergency equipment suitable to treat both adults and children. Examples included an automated external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm), oxygen and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).
- Emergency medicines were held to treat a range of sudden illness that may occur within a general practice. All medicines were in date, stored securely and staff knew their location.
- An up to date business continuity plan detailed the practice response to unplanned events such as loss of power or water system failure.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Staff kept up to date by subscribing to evidence based practice change alerts and were able to access guidance and information through the practice computer system.
- Changes to guidelines were shared and discussed at weekly practice meetings.

Management, monitoring and improving outcomes for people

The practice had been proactive in evaluating the care provided to patients and they had expanded their services to meet their needs.

- Under a clinical commissioning group (CCG) local incentive scheme (LIS) the practice had recruited a clinical pharmacist on a full time basis in 2014. There was a primary focus at improving the outcomes for patients with long-term conditions including Chronic Obstructive Pulmonary Disease (COPD). Outcome data showed that outcomes for patients with COPD had improved, For example, in 2013/14 the practice had achieved 80% of the total points available in the six Quality and Outcomes Framework (QOF) indicators related to COPD. In 2014/15 the practice had achieved 100% of the total points available. (QOF is a system intended to improve the quality of general practice and reward good practice)
- The practice was effective at identifying patients with long-term conditions. In 16 out of 19 outcomes in QOF the practice had identified more patients with a condition than the CCG average.
- The practice participated in a number of additional services including providing care plans and rapid care reviews to patients at the highest risk of unplanned admission to hospital, minor surgery and spirometry.

The practice used the information collected for QOF and performance against other local and national data to monitor outcomes for patients. QOF results from 2014/15 showed that within the practice:

- The practice achieved 98% of the total number of points available; this was higher than the national average and CCG averages of 95%.
- Clinical exception reporting was 9%, which was the same as CCG and national levels. Clinical exception rates allow practices not to be penalised, where, for example, patients do not attend for a review, or where a medicine cannot be prescribed due to side effects. Generally lower rates indicate more patients have received the treatment or medicine.
- 99% of patients with enduring poor mental health had a recent comprehensive care plan in place compared with the CCG and national averages of 90%. Clinical exception reporting was higher at 21% compared to the CCG average of 8% and national average of 10%. The higher exception reporting was due to a number of patients in this demographic already having a combined care plan in place for avoiding unplanned admission to hospital. We reviewed the care given to some patients in this group and saw it was to a good standard and reflected nationally recognised guidance.
- 75% of patients with asthma had a review of their condition within the previous year. This was the same as the CCG and national averages. Clinical exception reporting was 2% compared to the CCG average of 6% and national average of 8%.
- 92% of patients with dementia had a face to face review of their condition in the last 12 months. This was higher than the CCG average of 85% and national average of 84%. Clinical exception reporting was 3% compared to the CCG and national averages of 8%.

We reviewed data from the CCG Quality Improvement Framework (QIF) which is a local framework run by NHS Stoke on Trent CCG to improve the health outcomes of local people. During 2014/15 QIF data showed that emergency admissions rates to hospital for patients with conditions where effective management and treatment may have prevented admission were in line with the local

Good

Are services effective?

(for example, treatment is effective)

average. Of note the practice, over four years, had reduced the number of patients in this demographic who were admitted to hospital by more than four times the average CCG reduction.

The practice used local and nationally recognised pathways for patients whose symptoms may have been suggestive of cancer. Data from 2014/15 from Public Health England showed that 57% of patients with a newly diagnosed cancer had been referred via a fast track method (commonly known as a two week wait). This was higher than the CCG average of 55% and national average of 48%. Earlier identification and appropriate referral is generally linked with better outcomes for patients in this group.

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

Clinical audit was deeply embedded within the practice and encompassed a wide range of subjects including condition detection, effective medicines usage and health screening. The practice had completed over 16 audits in the previous two years. Five of these audits were two cycle completed audits. Themes of the audits were varied and included topics such as appropriate antibiotic usage, diabetic care and prevalence of medical conditions. Findings from audits were shared and acted upon to enable learning and improvement in practice.

Effective staffing

The practice had an experienced, well trained and motivated clinical, nursing and administrative team.

- A number of clinical staff had completed extended training in long-term conditions including diabetes, family planning and substance misuse.
- In view of GP recruitment challenges faced both locally and nationally, the practice expanded the skill mix of their staff. A clinical pharmacist and more advanced nurse practitioners had been employed to assess and treat patients with long-term conditions and acute minor ailments.
- Education was an integral part of the practice. The practice was an established teaching and training placement for medical students and GP registrars.
- Staff understood their patient demographic and practice performance and tailored the services to meet patient need.
- All staff had undertaken relevant and recent training in areas such as basic life support and safeguarding.
- The staff we spoke with were engaged, confident and knew their individual responsibilities.
- Staff told us they had been supported to develop. For example, an advanced nurse practitioner (ANP) and pharmacist had been supported to complete training to become independent prescribers.

Coordinating patient care and information sharing

The practice had a system for receiving information about patients' care and treatment from other agencies such as hospitals, out-of-hours services and community services. Staff were aware of their own responsibilities for processing, recording and acting on any information received. We saw that the practice was up to date in the handling of information such as discharge letters and blood test results.

All patient attendances to A&E were reviewed by a senior clinical team member to establish if patients required any follow up actions. This was clearly recorded in a tracking system. A particular focus of the practice was to explore the reasons for any patient aged 65 and over attending A&E or being admitted to hospital in unplanned circumstances. An ANP assessed the circumstances for admission and when necessary contacted patients to establish any additional support or intervention was required.

The practice team met on a regular basis with other professionals, including palliative care and community nurses, to discuss the care and treatment needs of patients approaching the end of their life and those at increased risk of unplanned admission to hospital.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Good

Are services effective?

(for example, treatment is effective)

- The process for seeking consent was monitored through records' audits to ensure it met the practice's responsibilities within legislation and followed relevant national guidance.
- Important issues surrounding decisions on when patients decided when to receive or not receive treatment were discussed and recorded to nationally accepted standards. For example, we saw when patients had decided not to receive resuscitation, the decision had been discussed, recorded and where appropriate those close to them had been involved in all stages of the process.

Supporting patients to live healthier lives

The practice offered a range of services in house to promote health and provided regular review for patients with long-term conditions:

- NHS Health Checks were offered to patients between 40 and 74 years of age to detect emerging health conditions such as high blood pressure/cholesterol, diabetes and lifestyle health concerns.
- The practice offered a comprehensive range of travel vaccinations.
- Immunisations for seasonal flu and other conditions were provided to those in certain age groups and patients at increased risk due to medical conditions.
- Childhood immunisation rates ranged from 98% to 100% and were higher than the CCG average in all indicators.
- New patients were offered a health assessment with a member of the nursing team, with follow up by a GP when required.
- The practice's uptake for the cervical screening programme was 76% which was lower than the CCG average of 80% and national average of 82%. Clinical exception reporting in this outcome was 4% compared to the CCG and national average of 6%.

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

- 73% of eligible females aged 50-70 had attended screening to detect breast cancer .This was similar to the CCG average of 75% and national average of 72%.
- 57% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer. This was similar to the CCG averages of 55% and national average of 58%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

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

We received two statements from members of the patient participation group (PPG) and invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 26 completed cards, of which all were positive about the caring and compassionate nature of staff. Patients told us they were treated with care, dignity, respect and understanding. There was a theme of caring and dignified service provision through the comments reviewed.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey published in January 2016. The survey invited 265 patients to submit their views on the practice, a total of 106 forms were returned. This gave a return rate of 38%.

The results from the GP national patient survey showed patients were satisfied with how they were treated. For example:

- 84% described their overall experience of the GP practice as good compared to the clinical commissioning group (CCG) average of 87% and national average of 85%.
- 84% said the GP was good at treating them with care or concern compared to the CCG average of 84% and national average of 85%.
- 95% had confidence in the last GP they saw or spoke with which was the same as the CCG and national averages.
- 87% said the GP was good at giving them enough time which was the same as the CCG and national averages.
- 93% said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 96% had confidence in the nurse compared to the CCG and national averages of 97%.
- 90% said the nurse was good at treating them with care or concern compared to the CCG average of 92% and national average of 91%.
- 84% found receptionists helpful compared to the CCG average and national averages of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 86% said the last GP they saw was good at involving them about decisions about their care compared to the national average of 82%.
- 86% said the last GP they saw was good at explaining tests and treatments which was the same as the CCG and national averages.
- 87% said the last nurse they saw was good at involving them about decisions about their care which was the same as the national average.
- 89% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 90%.

Patient/carer support to cope emotionally with care and treatment

Patients and carers gave positive accounts of when they had received support to cope with care and treatment. We heard a number of positive experiences about the support and compassion they received. For example, a patient told us about the particularly supportive and compassionate

Good

Are services caring?

way the practice staff had supported a relative with a serious illness. Comments related to all practice staff, although one GP in particular received six comments about their caring, compassionate approach.

The practice's computer system alerted staff if a patient was also a carer. The practice had identified 229 patients as carers (2.8% of the practice list). The practice had performed a recent audit to establish the services they provided to carers. A total of 81% of carers had received a physical health assessment although the practice identified that self-care advice and healthy minds advice was lower than expected. This had been discussed and improvements planned. The practice signposted carers to other agencies and promoted they availability of support on their website and within the waiting room.

If a patient experienced bereavement, practice staff told us that they were supported by a GP with access and signposting to other services as necessary.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

- The practice had taken action following patient and staff feedback about high patient demand for appointments. A GP provided daily cover as a 'floor walker' each morning. This was to directly support staff to flow patients to the most suitable appointment for their needs. Patients had the benefit of, when appropriate, being able to talk with the GP directly to discuss their issue. The practice was able to demonstrate that the GP was able to resolve around 75% of issues at the time of the call. Previously this would have resulted in an on the day appointment being taken. Commonly the GP was dealing with in excess of 20 patient contacts each morning as a floor walker.
- The practice had changed their opening hours to 7:30am each morning, providing earlier appointments and also later appointments in the evening until 7:30pm once a week.
- Two per cent of patients had been identified as being at increased risk of unplanned admission to hospital. Patients had a comprehensive care plan in place which was reviewed on a regular basis. If patients in this group were admitted to hospital, a GP reviewed their care on discharge from hospital.
- Home visits, including vaccinations were provided to older patients and patients who would benefit from these.
- Practice staff endeavoured to coordinate care in one visit, for example if a blood test was required it would be done at the time of appointment reducing the need for a return visit.
- Access to the practice was via a single level, corridors and doorways were wide to promote access for those with mobility issues.

The practice performance within the clinical commissioning group (CCG) area showed less of their patients attended A&E than average. We looked at 2014/15 data from the Quality Improvement Framework (QIF) which is a local framework run by NHS Stoke on Trent CCG to improve the health outcomes of local people. The data showed that:

- The number of patients attending A&E during GP opening hours was lower than the CCG average. With an average of 101 patients per 1,000 attending A&E during opening hours compared with a CCG average of 104 per 1,000.
- The overall number of patients attending A&E at any time was also lower than the CCG average. With an average of 243 patients per 1,000 attending A&E at any time compared with a CCG average of 257 per 1,000 patients.
- Performance over time and in particular from 2012 to 2015 the practice showed little change in the number of their patients attending A&E compared to a 6% rise in the CCG average.

Access to the service

The practice had their opening times displayed within the premises and detailed on their website:

- The reception was open 7:30am to 6pm Monday, Wednesday and Friday, 7:30am to 7:45pm on Tuesday and 7:30am to 1pm on Thursday.
- Telephone access for routine appointments and queries was available Monday, Wednesday and Friday 8am to 12pm then 2pm to 6pm, Tuesday 8am to 11:30am then 2:30pm to 6pm and Thursday 8am to 1pm. Outside of these hours each weekday patients could telephone an alternative telephone number for urgent assistance, the reception was also open.
- In line with local arrangements the practice closed at 1pm each Thursday. Patients could access assistance at this time and the out-of-hours service by telephoning the practice telephone number from where their call was transferred to the local out-of-hours provider.
- All requests for home visits were assessed by a GP or advanced nurse practitioner. This was to ensure that the agreed timeframe was suitable in the circumstances. Also to provide clinical safety netting advice in case of any worsening in the condition of the patient.

Patients could book appointments in person, by telephone or online for those who had registered for this service. The

Good

Are services responsive to people's needs?

(for example, to feedback?)

availability of appointments was a mix of book on the day or routine book ahead. We saw that the practice had same day availability for urgent appointments and routine appointments with GPs and nurses within the following three working days.

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

- 69% of patients found it easy to contact the practice by telephone compared to the CCG average of 77% and national average of 73%. The practice was aware of this and had an action plan in place to review and improve performance.
- 95% of patients said the last appointment they made was convenient compared to the CCG average of 94% and national average of 92%.
- 75% of patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 79% of patients said they were able to get a convenient appointment the last time they tried compared to the CCG and national averages of 76%.

Comments we received from patients about access to the practice were mostly positive. Two patients commented less positively although no themes were identified.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Information was available to help patients understand the complaints system and the complaints process was displayed on notice boards and a practice leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice had received 11 complaints in the last 12 months. We tracked two complaints and saw they had been acknowledged, investigated and responded to in line with the practice complaints policy.

The practice carried out a thorough analysis of the complaints received. They looked for trends and compared year on year performance to look for emerging issues. Findings were shared with staff and the patient participation group (PPG). Following consultation a yearly action plan was developed. Themes of action planned for 2016/17 included to evolve patient interaction with the practice to include different modes of technological consultation and to evaluate the infrastructure of the existing telephone system.

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 did not have a written vision and values although staff told us of their desire to provide high quality and empathetic patient care.

The practice had a number of supporting business plans which set out clearly their future developments benchmarked against national strategies.

Every opportunity had been taken to maximise the opportunity to provide additional services for patients. The practice had signed up to a high number of Directed Enhanced Services and Local Improvement Schemes to provide more services for their patients.

Governance arrangements

Governance within the practice was strong and decisive. The practice team had an overview of risks and took every opportunity to mitigate them:

- Areas of governance such as the management of medicines and infection prevention and control were allocated to members of the practice team. The staff we spoke with knew their responsibilities and were confident and knowledgeable.
- The practice achieved better than average results in Quality and Outcomes Framework (QOF) and Quality Improvement Framework (QIF). (QOF is a system intended to improve the quality of general practice and reward good practice, QIF is a local framework run by NHS Stoke on Trent CCG to improve the health outcomes of local people).
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

During our inspection there was a common finding of effective leadership. The practice had experienced extreme challenges in 2014 with the loss of a number of GPs. Within the local area and nationally the number of GP vacancies presented further difficulty to the practice to fill the vacancies. The leadership team had analysed the reasons for higher than expected staff turnover which was given as workload including the more hidden task elements of general practice. A number of improvements were made including the expansion of the clinical team to include more advanced nurse practitioners and a full time clinical pharmacist. This action allowed the wider sharing of management of medicine reviews, acute illness presentation and review of communications relating to patient care to be shared. This had a led to an increase in the time that GPs were available to see patients with more complex health needs.

The practice introduced a concept of a duty senior clinical team working on a daily basis. The senior clinical team was made up of GPs, advanced nurse practitioners and a pharmacist. Duties were shared to the strengths of the individual ensuring support was available when needed. The staff we spoke with were positive about the leadership within the practice and felt the senior clinical team were approachable and visible at all times.

The administrative and business leadership team was led by a managing partner who had 40 years' experience of working at the practice, many of which were in a senior role. The whole team knew their responsibilities and had total oversight of the day to day operation of the practice.

The managing business partner performed a number of governance checks to ensure that the practice was meeting their own policy standards. For example, regular audits that cleaning was effective and the premises supported infection control prevention standards.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried

Are services well-led?

Good

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

out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice was working with the PPG to improve patient experiences of making an appointment.

Staff told us they felt able to make suggestions to the way the practice provided services and were encouraged to do this at staff meetings or as needed.

Continuous improvement

A culture to promote continuous improvement was evident throughout the practice. For example, the introduction of a clinical pharmacist with responsibility had improved performance in the outcomes for Chronic Obstructive Pulmonary Disease (COPD). Another example of improvement was to maximise the opportunity for patients with long-term conditions to receive a review of their condition the practice implemented a system of regular audits to ensure that the clinical record coding of conditions was accurate. A number of audits were run to ensure that patients were invited to have their condition reviewed. The practice performance in QOF was higher than local and national averages and a senior member of the practice team told us the practice would always try to improve despite already performing favourably.

The practice was a teaching and training practice and staff told us they had been supported to develop professionally. For example, an advanced nurse practitioner told us how they had been supported to develop as an independent prescriber.

We spoke with two GP registrars who told us the practice had been very highly supportive of them during their training to become qualified GPs