

Dr N Mudigonda & Dr V Mudigonda

Quality Report

Dr N Mudigonda & Dr V Mudigonda

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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

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

Detailed findings from this inspection

Our inspection team	10
Background to Dr N Mudigonda & Dr V Mudigonda	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr N Mudigonda and Dr V Mudigonda on 7 March 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
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Feedback from patients about their care was consistently positive. 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 that 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 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.

The areas where the provider should make improvement are:

Summary of findings

- Review the arrangements to demonstrate the appropriateness of decisions taken following the receipt of criminal records checks that may identify negative outcomes.

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. 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, relevant information and an apology. They were also told about any actions to improve processes to prevent the same thing happening again. The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse. Risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated as good for providing effective services. Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were similar to the average for the locality and the national average. Staff assessed needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all staff. Staff worked with other health and social care professionals to understand and meet the range and complexity of patients' needs.

Good



Are services caring?

The practice is rated as good for providing caring services. Data from the national GP patient survey showed patients rated the practice similar to others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. 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. Patients were encouraged to let the practice know if they were a carer and were asked to complete information forms online or in paper format with their details. This information helped to ensure that carers received appropriate support. Priority appointments were available for carers and patients who were cared for.

Good



Are services responsive to people's needs?

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

Good



Summary of findings

these were identified. The practice had a register of patients who had been identified as homeless. These patients were regularly discussed at what the practice called a 'Hotlist Clinic'. The practice liaised with other organisations on their behalf to help meet their holistic needs. The practice manager was qualified to provide non-clinical advice to patients on how to make and put in place an advance decision plan.

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. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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 aware of the vision and their responsibilities in relation to this. 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 knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken. 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.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and all patients aged 65 years and under had a named GP. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered home visits and urgent appointments for those older patients who were housebound and with enhanced needs. The practice had a small number of older patients who lived in care homes and ensured that their needs were met through proactive contact with staff working at the three care homes. The local prescribing advisor linked to the practice carried out medicine reviews with patients over 65 years who were taking four or more medicines.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. The GPs and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice performance for five diabetes assessment and care related indicators varied slightly. For example the percentage of patients with diabetes, on the register, who had a record of a foot examination and a risk classification related to foot health completed, was 82% which was lower than the national average of 88%. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading in the last 12 months was at or below a given measurement, was higher than the national average (84% compared to the national average of 78%). QOF is a system intended to improve the quality of general practice and reward good practice.

Daily emergency appointments, longer appointments and home visits were available when needed for these patients. A structured annual review to check their health and medicines needs were being met was carried out and patients had a named GP. The practice nurse had ensured that care plans were developed to support the ongoing effective management of patients with long term conditions. For those patients with the most complex needs, the named GP and nursing staff 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. There were systems in place to identify and follow up

Good



Summary of findings

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. 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. The premises were suitable for children and babies. Protected appointments were allocated for children and appointments were available outside of school hours. We saw positive examples of joint working with midwives and health visitors. Child health surveillance which included postnatal and six week baby checks were offered at the practice. The practice's uptake for the cervical screening programme was 77%, which was lower than the national average of 82%.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The 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. Extended hours were offered two evenings per week. The practice was proactive in offering online services which included repeat prescription ordering and access to patient records. A full range of health promotion and screening that reflected the needs for this age group were also available.

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. This included a register of patients who had problems with substance misuse. The senior partner held a fortnightly shared clinic at the practice in partnership with a local substance misuse recovery support service. The clinic was open to both patients registered at the practice and those not registered with the practice but who lived in Wolverhampton. The practice also had a register of patients who had been identified as homeless. These patients were regularly discussed at what the practice called a 'Hotlist Clinic'. A register of patients with a learning disability was held and all these patients were offered an annual health check with the support of the local community learning disability team. Longer appointments were offered to patients with a learning disability and an easy read (pictorial) letter was sent inviting them to attend the practice for their annual health check. Staff had been trained to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding confidentiality, information sharing, documentation of safeguarding concerns and how to contact

Good



Summary of findings

relevant agencies. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

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 percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 83%, which was similar to the national average of 84%. The data related to mental health showed that 93% of patients on the practice register who experienced poor mental health had a comprehensive agreed care plan in the preceding 12 months. This was higher than the national average of 88%. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. The practice manager was qualified to provide non-clinical advice on how to make and put in place an advance decision plan for patients with dementia. The practice offered patients who experienced poor mental health continuity of care and appointments with the senior GP partner who was qualified in and had experience in managing patients with complex mental health conditions. Staff had a good understanding of how to support people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016 showed the practice was performing above the local and national averages in most areas. A total of 378 surveys (10.3% of patient list) were sent out and 110 (29.1%) responses were received, which is equivalent to 3% of the patient list. Results indicated the practice performance was higher than or similar to other practices in most aspects of care. For example:

- 73% found it easy to get through to this surgery by phone compared to the local Clinical Commissioning Group (CCG) average of 70% and a national average of 73%.
- 88% were able to get an appointment to see or speak to someone the last time they tried (CCG average 82%, national average 85%).
- 91% described the overall experience of their GP surgery as fairly good or very good (CCG average 81%, national average 85%).
- 72% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 71%, national average 78%).

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 40 comment cards which were overall positive. Patients said that they were pleased with the service offered, reception staff were excellent, friendly and approachable, patients said that the GPs and nurses listened, explained and provided printed information on their treatment and gave advice. We spoke with three patients which included a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

The practice monitored the results of the friends and family test monthly. The results for the period January 2015 to February 2016 showed that of the 328 responses, 219 patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment and 100 patients were likely to recommend the practice.

Areas for improvement

Action the service **SHOULD** take to improve

- Review the arrangements to demonstrate the appropriateness of decisions taken following the receipt of criminal records checks that may identify negative outcomes.

Dr N Mudigonda & Dr V Mudigonda

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Dr N Mudigonda & Dr V Mudigonda

Dr N Mudigonda and Dr V Mudigonda practice is registered with the Care Quality Commission (CQC) as a two GP partnership. The practice has good transport links for patients travelling by public transport and parking facilities are available for patients travelling by car. The practice is a single floor building. There is level access to the building and all areas are easily accessible by patients with mobility difficulties, patients who use a wheelchair and families with pushchairs or prams.

The practice team consists of two GP partners and a salaried GP (all male). The clinical practice team include a nurse practitioner and a healthcare assistant. Clinical staff are supported by a practice manager, a practice coordinator and five administration / receptionist staff. In total there are 12 staff employed either full or part time hours to meet the needs of patients. The practice also use regular GP locums when needed to support the clinicians and meet the needs of patients at the practice. The practice is a training practice for GP trainees.

The practice is open between 8am and 6.30pm Monday and Friday, 8am to 7.30pm Tuesday, 8am to 7.15pm Wednesdays and 8am to 12.30pm on a Thursday. Appointments are from 9.30am to 12.30pm every morning, 4pm to 6pm Monday and Friday, 4pm to 7.30pm Tuesday and 4pm to 7.15pm on Wednesday. Extended hours appointments are offered at the following times 6.30pm to 7.30pm on Tuesdays and 6.30pm to 7.15pm on Wednesdays. The practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours service, the NHS 111 service and the local Walk-in Centres.

The practice has a General Medical Services contract with NHS England to provide medical services to approximately 3,662 patients. It provides Directed Enhanced Services, such as the childhood immunisations, minor surgery and asthma and diabetic clinics. The practice is located in one of the most deprived areas of Wolverhampton. People living in more deprived areas tend to have greater need for health services. The practice has a slightly higher proportion of patients aged between five and nine, 20 to 24, female patients aged 45 to 49, male patients aged 50 to 69 and older patients aged 70 years and over when compared with the practice average across England. For example, the percentage of patients aged 65 and above at the practice is 31% which is slightly higher than the local Clinical Commissioning Group (CCG) and the national average of 27%. There is a significantly higher than national average representation of income deprivation affecting children (39% compared to 20%) and older people (31% compared to 16%).

Detailed findings

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 visiting, 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 inspection on 7 March 2016.

During our visit we:

- Spoke with a range of staff including GPs, practice nurses, and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.

- 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.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents. Staff completed an incident recording form which supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, relevant information, an apology and were told about any actions to improve processes to prevent the same thing happening again. The practice carried out a thorough analysis of the significant events to ensure appropriate action was taken.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were reported and discussed. We saw evidence that lessons were shared and action taken to improve safety in the practice. We saw records of significant events that had occurred at the practice from 2009. We looked at eleven significant events both clinical and operational that had occurred over the past year. One of the events showed that a request for information about a patient's attendance at the practice had been incorrectly handled and the wrong information shared with professionals outside of the practice. The investigation showed that the incident had been unnecessarily escalated as a safeguarding concern. Discussions were held and the minutes of meetings demonstrated that appropriate learning from events had been shared with staff and external stakeholders. The staff involved received supervision and procedures were reviewed to ensure that all staff were aware of the process to follow when sharing information and the need to confirm requests made by callers to the practice. The process was also monitored to prevent reoccurrence.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse.

Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and

local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the GPs was the lead for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff we spoke with demonstrated that they understood their responsibilities and most staff had received training relevant to their role. Certificates of safeguard training at the appropriate level were seen and arrangements were in place for one member of non-clinical staff to complete the training. The practice had updated the records of vulnerable patients to ensure safeguarding records were up to date. The practice shared examples of occasions when suspected safeguarding concerns were reported to the local authority safeguarding team. Our review of records showed appropriate follow-up action was taken where alleged abuse occurred to ensure vulnerable children and adults were safeguarded from the risk of harm. Children and adults identified as being at risk of harm or abuse were discussed at monthly practice meetings.

A notice displayed in the waiting room, information in the practice leaflet and on the practice website advised patients that they could access a chaperone, if required. All staff who acted as chaperones were trained for the role. Staff files showed that criminal records checks had been carried out through the Disclosure and Barring Service (DBS) for staff who carried out chaperone duties. (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 maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy and this was confirmed by the comments made by patients in the Care Quality Commission (CQC) comment cards sent to the practice. The practice had an infection control policy and supporting procedures were available for staff to refer to. There were cleaning schedules in place and cleaning records were kept. Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons. Hand gels for patients and staff were available. Clinical waste disposal contracts were in place. The nurse practitioner was the clinical lead for infection control.

Are services safe?

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice had processes in place for handling and reviewing repeat prescriptions which included the review of high risk medicines. The practice had arrangements in place for patients or their representative to sign for the receipt of prescriptions for controlled drugs (medicines that require extra checks and special storage because of their potential misuse). Regular medication audits were carried out with the support of the local clinical commissioning group (CCG) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The local prescribing advisor linked to the practice carried out medicine reviews with patients over 65 years who were taking four or more medicines. Prescription pads were securely stored and appropriate systems were in place to track and monitor their use. The practice had a nurse practitioner who was qualified as an independent prescriber. They could prescribe medicines for specific clinical conditions. The nurse received mentorship and support from the medical staff for this extended role. Patient Specific Directions had been adopted by the practice to allow the health care assistant to administer specific medicines in line with legislation.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We found that the practice did not have a system in place to explain and record their decision following the receipt of criminal records checks with negative information.

Monitoring risks to patients

Risks to patients were assessed and well managed. There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception area. The practice had a comprehensive risk assessment system in place to monitor and mitigate any risks to the safety of the premises. These included risk assessments for safe sharps practices, electrical wires under desks, control of substances hazardous to health and infection control.

The health centre where the practice was located was managed and maintained by NHS property services. They provided the practice with information to demonstrate that an up to date fire risk assessment had been carried out. The outcome of fire drills that had taken place in October 2014 and August 2015 was made available. These showed details of the action that needed to be taken to make improvements and mitigate risks identified following the drills. All electrical equipment was checked in March 2016 to ensure the equipment was safe to use and clinical equipment was checked in May 2015 to ensure it was working properly. The property services team also had a policy for the management, testing and investigation of legionella (Legionella is a term for a particular bacterium that can contaminate water systems in buildings). They had advised the practice that a legionella risk assessment had been carried out in December 2013 and arrangements were in place to repeat the assessment in February 2016. The practice provided a copy of the report as evidence that the risk assessment had been repeated on 2 February 2016. The practice manager also confirmed that they had asked the property services team for confirmation that action had been taken to address the two recommendations specifically related to the practice.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff and staff with appropriate skills were on duty. The practice used locum GPs to help meet the needs of patients at times of GP absence such as annual leave. A GP locum recruitment and induction pack was available to ensure appropriate checks were carried out to confirm the suitability of potential staff to work with patients.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The practice had a business continuity plan in place for major incidents such as power failure or loss of access to medical records. The plan included emergency contact numbers for staff and mitigating actions to reduce and manage the identified risks.

There were emergency procedures and equipment in place to keep people safe. Emergency medicines were available

Are services safe?

in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date.

All staff had received annual basic life support training. The practice had a defibrillator (this provides an electric shock to stabilise a life threatening heart rhythm) available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' 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 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 systems were in place to keep all clinical staff up to date. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and reviewed their performance against the national screening programmes to monitor outcomes for patients. The practice achieved 97% of the total number of points available for 2014-2015. This was similar to the practice average across England of 95%. The practice clinical exception rate of 8.8% was higher than the local Clinical Commissioning Group (CCG) average of 7.5% but lower than the national average of 9.2%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Further practice QOF data from 2014-2015 showed:

- Performance for the assessment and care of patients diagnosed with diabetes was higher than the national average (93% compared to the national average of 89%). The practice clinical exception rate was 10.9% for this clinical area. This was higher than the local CCG average of 8.8% and similar to the national average of 10.8%.
- Performance for mental health assessment and care was higher than the national average (93% compared to

the national average of 88%). The practice clinical exception rate of 7.1% for this clinical area was lower than the local CCG average of 8.4% and national average of 11.1%.

- The dementia diagnosis rate was similar to the national average (83% compared to the national average of 84%). The practice clinical exception rate of 8.3% for this clinical area was higher than the local CCG average of 7.7% and the same as the national average.

The practice was performing well when compared to the local average. However there was one indicator that required further enquiry. Data for the period April 2014 to March 2015 showed that the practice had a lower ratio of reported versus expected prevalence for Coronary Heart Disease (CHD) than the national average (0.48 compared to the national figure of 0.71). The practice was aware of this and had put processes in place to address the issues. For example, laminated prompt posters with relevant coding information were displayed in consulting rooms so that clinical staff were supported to use the appropriate diagnosis code. The practice had also carried out a review of patients on the practice CHD register, which included patients who were not compliant with their treatment. Regular meetings were held to monitor performance and an action plan was developed at each meeting to identify the areas of patients' care that needed to be reviewed. Evidence was available to show that the practice had a robust system in place to follow up patients that had not attended at least annual reviews of their condition when offered an appointment.

The practice held meetings weekly, which they called 'Hot Clinics' where patients considered to be at high risk or that required regular monitoring were discussed. The meetings were attended by the GPs and GP registrar. Patients discussed at these meetings included frequent attenders to the practice, patients who were dependent on controlled drugs (CDs) and those who were registered as homeless. The clinics were also used to monitor referrals through the fast track system for patients who were suspected of having cancer, patients who did not attend their national cancer screening appointments and to follow up patients discharged from hospital.

Clinical audits were carried out to facilitate quality improvement and all relevant staff were involved in the practice aim to improve care and treatment and patient outcomes. We looked at three audits carried out over the

Are services effective?

(for example, treatment is effective)

past year. A second cycle had been completed for all of the audits to review whether improvements had been made. For example, the practice had completed an audit which looked at the uptake of the influenza vaccine by eligible patients registered at the practice. The practice was also concerned that it had never achieved the 70% recommended standard set by the local CCG. Audits were carried out over two flu campaign years and results showed that following a robust patient awareness campaign that uptake of the influenza vaccine had increased from 63.1% to 69.3% an increase of 6.2%. Plans were in place to repeat the campaign and the audit. Further audits completed included antibiotic prescribing and an audit of emergency appointment usage.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for all newly appointed staff. All staff received training that included safeguarding, fire safety, health and safety, confidentiality and infection prevention and control. Locum GPs used at the practice received an induction pack to support them when working at the practice.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had had an appraisal within the last 12 months. Staff had access to specific and appropriate training to meet their learning needs and to cover the scope of their work. The practice could demonstrate how they ensured role-specific training and updating for relevant staff was completed. For example, staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.

The nurse practitioner was fully trained to deliver a number of services and had received training specific to meeting the needs of patients with long-term conditions, such as diabetes, heart disease, asthma and high blood pressure. Staff had access to and made use of e-learning training modules, in-house training and attendance at external training sessions. The practice had discussed with the nurse practitioner the support needed for revalidation (A formal process requiring nurses and midwives to demonstrate that they practise safely). Information was available to confirm that GPs were up to date with revalidation requirements.

Coordinating patient care and information sharing

Staff shared the premises with other health and social care professionals who offered patients ease of access to other health care services in the same building. Services and professionals available included; physiotherapy, a midwife, health visitor, family planning, healthy minds counselling and a phlebotomist (a person who is trained to take blood samples from patients for testing and the results used to diagnose diseases and monitor treatments).

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

This included care and risk assessments, care plans, medical records, clinical investigations and test results. Information such as NHS patient information leaflets was also available. The practice shared relevant information with other services in a timely way, for example when referring patient's to secondary care such as hospital or to the out of hours service.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a three monthly basis to monitor the care and treatment of patients requiring palliative care. The care plans for these patients and those with complex needs were routinely reviewed and updated.

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.

Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits.

Supporting patients to live healthier lives

Are services effective?

(for example, treatment is effective)

The practice identified patients who may be in need of extra support. These included patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant support service. Patients had access to appropriate health assessments and checks. These included health checks for new patients and patients aged 40 to 74 years. The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance.

Data for the uptake of childhood immunisations collected by NHS England for the period April 2014 to March 2015 showed that the practice performance for all childhood immunisations was similar to or higher than the local CCG average. For example, immunisation rates for the

vaccination of children aged five year olds ranged from 89% to 100% (local CCG 77% to 95%). Children who did not attend their appointment were proactively followed up by the nurse practitioner. A letter was sent to the parents following the first unattended appointment and a further appointment given. If the child failed to attend the second appointment the health visitor was contacted.

The practice's uptake for the cervical screening programme was 77%, which was lower than the national average of 82%. There was a policy to follow up with patients who did not attend for their cervical screening test. The practice was proactive in following these patients up by telephone and sent reminder letters. Public Health England national data showed that the practice was comparable with local and national averages for screening for cancers such as bowel and breast cancer.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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. Curtains were provided to maintain patients' privacy and dignity during examinations, investigations and treatments. We saw that reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and patients were offered a private area where they could not be overheard to discuss their needs.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 40 completed cards. The cards contained overall positive comments about the practice and staff. Patients commented that the service was excellent, they were treated with respect and dignity and that GPs and staff were professional, friendly, helpful, knowledgeable and caring. We also spoke with three patients on the day of our inspection which included a member of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

Results from the national GP patient survey published in January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average or similar to local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% said the GP was good at listening to them compared to the local clinical commissioning group (CCG) average of 83% and national average of 89%.
- 95% said the GP gave them enough time (CCG average 83%, national average 87%).
- 98% said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).

- 91% said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).
- 89% said the last nurse they spoke to was good at treating them with care and concern (CCG average 89%, national average 91%).
- 87% said they found the receptionists at the practice helpful (CCG average 85%, national average 87%).

Care planning and involvement in decisions about care and treatment

- Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. We saw that care plans were personalised to reflect patients individual care needs. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 87% said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%).
- 87% said the last nurse they saw was good at involving them in decisions about their care (CCG average 83%, national average 85%).

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. There were 49 carers on the practice carers register, which represented 1.3% of the practice population. The practice's computer system alerted GPs if a patient was also a carer. Patients were encouraged to let the practice know whether they were a carer and were

Are services caring?

asked to complete information forms online or at the practice with their details. This information helped to ensure that the carer received and was signposted to appropriate support. Written information was available for carers to ensure they understood the various avenues of support available to them. A poster was displayed on a noticeboard, displayed on an electronic screen and on the practice website. Priority appointments were available for carers and patients who were cared for.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. Services were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- A fortnightly shared clinic was held at the practice in partnership with a local substance misuse recovery support service. The clinic was open to both patients registered at the practice and those registered at other practices within Wolverhampton.
- The practice offered patients who experienced poor mental health continuity of care and appointments with the senior GP partner who was qualified and had experience in managing patients with complex mental health conditions.
- The practice had a register of patients who had been identified as homeless. These patients were regularly discussed at what the practice called a 'Hotlist Clinic'. The practice liaised with other organisations on their behalf to help meet their holistic needs.
- The practice manager was qualified to and provided non-clinical advice to patients on how to make and put in place an advance decision plan.
- The practice were actively addressing the lack of a female GP to support the needs of female patients. A female GP registrar was due to start GP training at the practice later this year. The practice was also looking at the recruitment of a female GP. There were advanced nurse practitioners and practice nurses who were able to meet some of the care needs of female patients such as cervical screening.
- The practice offered extended clinic appointments on Tuesday and Wednesday evenings for working patients who could not attend during the normal opening hours.
- Facilities for patients with mobility difficulties included level access to the automatic front doors of the practice and adapted toilets for patients with a physical disability.
- Baby changing facilities were available. Mothers were supported to breast feed their baby in an area acceptable to them which could be within the waiting area or a designated room.

- There were longer appointments available for patients with a learning disability, older people and patients with long-term conditions.
- Home visits were available for patients who were housebound and unable to attend the practice. The priority of the visit was based on the severity of their condition. The GP made a decision on the urgency of the patients need for care and treatment and the most suitable place for this to be received.
- Telephone consultations were available every day after morning and evening clinics.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.

Access to the service

The practice was open between 8am and 6.30pm Monday and Friday, 8am to 7.30pm Tuesday, 8am to 7.15pm Wednesdays and 8am to 12.30pm on a Thursday. Appointments were from 9.30am to 12.30pm every morning, 4pm to 6pm Monday and Friday, 4pm to 7.30pm Tuesday and 4pm to 7.15pm on Wednesday. Extended hours appointments were offered at the following times 6.30pm to 7.30pm on Tuesdays and 6.30pm to 7.15pm on Wednesdays. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients were directed to the out of hours service, the NHS 111 service and the local Walk-in Centres.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to the national averages.

- 83% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 73% patients said they could get through easily to the surgery by phone (73%, national average 73%).

The practice regularly reviewed the number of urgent appointments available and increased the number of same day appointments available to patients as appropriate. The practice discussed these changes with the patient participation group (PPG) and planned to review whether this had improved patients experience. People told us on the day of the inspection that they were able to get appointments when they needed them.

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. The practice operated a telephone triage system and patients were contacted following the morning and evening clinics. Non-clinical staff would refer any calls which caused concern or they were unsure of to a clinician for advice. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. Information in the patient leaflet and on the practice website informed patients to contact the practice before 9.30am if they required a home visit.

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. The practice manager was the designated responsible person who handled all complaints at the practice. We saw that information available to help patients understand the complaints system included leaflets available in the reception area and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We saw records for five complaints received over the past 12 months and found that all had been responded to, satisfactorily handled and dealt with in a timely way. Complaints raised varied and trends were not identified. Lessons were learnt from concerns and complaints and action was taken to improve the quality of care.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to provide effective, quality and personalised care to meet the health needs of all patients and promote good outcomes. Staff and patients felt that they were involved in the future plans for the practice. For example the practice sought the views of patients and input of the patient participation group (PPG) on improvements that could be made at the practice. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services.

Governance arrangements

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities and all staff were supported to address their professional development needs.
- We found that systems were supported by a strong management structure and clear leadership.
- A programme of clinical and internal audit had been implemented and was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Practice specific policies were implemented and were available to all staff.

Leadership and culture

The GPs at the practice had the experience, capacity and capability to run the practice and ensure high quality care. The GPs were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. The provider was aware of and complied with the requirements of the Duty of Candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong

with care and treatment). The partners encouraged a culture of openness and honesty. There were support systems in place for all staff on how to communicate with patients about notifiable safety incidents. When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, relevant information and a verbal and written apology.

There was a clear leadership structure in place and staff felt supported by the management. Staff we spoke with were positive about working at the practice. They told us they felt comfortable enough to raise any concerns when required and were confident these would be dealt with appropriately. Regular practice, clinical and team meetings which involved all staff were held and staff felt confident to raise any issues or concerns at these meetings. Topics on the agenda included day to day operation of the practice, health and safety, audits, complaints, significant events and other governance arrangements. All staff were involved in discussions about how to run and develop the practice, and the directors encouraged all members of staff to identify opportunities to improve the service delivered by the practice. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

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 practice sent out 200 surveys to patients during January and March 2015 of these 134 surveys were returned. The lack of confidentiality in the waiting area, telephone access and appointments were areas that patients highlighted as needing improvements. The results showed that 95% of patients who responded said that they were satisfied with the practice and their satisfaction with the service provided by the nurse was excellent or good. The practice had discussed the results of the survey in depth with patients at one of the PPG meetings. The practice had an active patient participation

Are services well-led?

Good 

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

group (PPG), the membership varied and meetings were open to other patients. Formal meetings were held every three months and minutes were available to confirm this. The practice manager attended the meetings to ensure that the members were updated on developments at the practice and locally. The practice and PPG were proactively looking at ways they could increase the number of PPG members.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

The practice had completed reviews of significant events and other incidents and had ensured that lessons learned from these were used to make improvements and prevent

further reoccurrence. The practice was accredited as a training practice for GP trainees. One of the GP partners was a prescribing tutor for nurses working in the local community.

The practice manager had completed a doctorate in mental capacity and had written an information booklet about advance planning. The practice manager was qualified to provide non-clinical advice to patients on how to make and put in place an advance decision plan. As part of its involvement in Dementia Awareness Week in 2015 the practice hosted a workshop on advance decision planning which was attended by patients and professionals. The practice received positive feedback on the workshop and had plans to host a similar workshop on a regular basis.

The practice held weekly meetings, which they called 'Hot Clinics'. The meetings were specifically to discuss patients considered to be at high risk or that required regular monitoring. The meetings were attended by the GPs and GP registrar and ensured patients holistic care needs were met and learning identified to support ongoing improvements.