MGS Medical Practice

Quality Report

MGS Medical Practice
Low Hill Medical Practice
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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

MGS Medical Practice comprises of three branches, Low Hill Medical Centre, Bradley Health Centre and Ruskin Road Surgery. We carried out an announced comprehensive inspection at Low Hill Medical Centre, the main branch on 27 May 2015. The other two branches were not inspected as part of this visit. Overall Low Hill Medical Centre is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. The practice was rated as good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of ensuring the skill mix of staff was appropriate to meet the needs of patients registered at the service.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- 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.
- Patients said it was not always easy to make an appointment with a named GP, that there was a lack of continuity of care and although urgent appointments were available the same day they found it difficult to access these.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- 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.

There were areas of practice where the provider needs to make improvements.

Action the provider should take to improve:

- Ensure that a suitable mix of staff with appropriate levels of skills and competencies are available to meet the needs of patients registered at the practice.
- Implement multidisciplinary meetings to discuss the care of patients at the end stage of their life and those with complex health needs.
- Review the appointment system offered to ensure patients can access the practice, a GP of their choice and appointments in a timely manner.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. The skill mix of staff at the practice was not sufficient to ensure that patients care needs were consistently and safely met. The staff rota showed that there was a reliance on the use of regular locum GPs. We saw that the practice employed more healthcare assistants than practice nurses. This restricted the level of support, care and treatment that could be offered to patients. For example this impacted on the availability of appointments for patients and treatments provided at evening clinics. The practice nurses provided 20 hours per week to cover the three practices. The GP partner and business manager confirmed that staffing had been reviewed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were below or comparable with those for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams, however multidisciplinary team meetings to discuss the care of patients who required end of life care, had complex care needs and those with long-term care needs had not taken place.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and was accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said that it was difficult to gain an urgent appointment and expressed concerns about the merging of the practice and the lack of continuity of GPs. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available, easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. The practice engaged with the PPG during the merger of the three practices and had responded to ideas they suggested to progress plans to extend the waiting area to improve patient access for patients.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. For example some staff had experienced difficulties with the recent merger of the three practices. The GP partner and business manager were implementing systems to manage the situation. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was small but active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. However we found that formal multidisciplinary meetings to discuss the care of patients at the end stage of their life and those with complex health needs were not in place.

Families, children and young people

Good

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 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 good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability. 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. 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.

People experiencing poor mental health (including people with dementia)

Good

Data showed that 82.4% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It 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. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. We saw that there was a psychologist attached to this practice who provided support for patients who experienced poor mental health.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection, one of whom was a member of the practice patient participation group (PPG). PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. We spoke with and received comments from patients who had been with the practice for a number of years and patients who had recently joined the practice. Patients we spoke with during the inspection were generally positive about the service they received. They told us that they were treated with respect, and were listened to. Patient's described the staff and GPs as always helpful, polite and professional. Some patients however expressed concerns about making appointments and not being able to get through to the practice on the telephone.

We reviewed 49 patient comment cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice two weeks before our inspection. We saw that the comments made varied about the service they experienced. Patients said that they always received good treatment; patients described their experience as wonderful and told us that staff were very kind and considerate. However some patients expressed concerns about making appointments and not being able to see the GP they wanted to see.

The January – March 2014 and July – September 2014 national GP patient survey showed that practice performed well in the following areas.

- 87% of respondents said that the last GP they saw gave them enough time at their appointment compared with local CCG average of 84%
- 83% of respondents said that the last GP they saw or spoke to treated them with care and concern as compared with the local CCG average of 80%
- 73% of respondents usually wait 15 minutes or less after their appointment time to be seen compared with the local CCG average of 62%

Areas where the practice performed less well than the CCG average were identified in the national patient survey and included:

- 58% of respondents said that they would recommend the practice to others as compared to the local CCG average of 72%
- 62% of respondents said that they found it easy to get through to the surgery by phone as compared to the local CCG average of 75%
- 71% of respondents said they were able to get an appointment when they wanted one as compared with the local (CCG) average of 82%

Areas for improvement

Action the service SHOULD take to improve

- Ensure that a suitable mix of staff with appropriate levels of skills and competencies are available to meet the needs of patients registered at the practice.
- Implement multidisciplinary meetings to discuss the care of patients at the end stage of their life and those with complex health needs.
- Review the appointment system offered to ensure patients can access the practice, a GP of their choice and appointments in a timely manner.

MGS Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team included a GP, practice manager, and an Expert by Experience. An Expert by Experience is someone who has extensive experience of using a particular service, or of caring for someone who has.

Background to MGS Medical Practice

Three practices Low Hill Medical Centre, Bradley Health Centre and Ruskin Road Surgery have recently merged to form MGS Medical Practice. Low Hill Centre is the main practice and the other two practices are branches, We carried out an announced comprehensive inspection at the Low Hill Medical Centre, the main practice site the other two branches were not inspected. Low Hill Centre and its branches provide services for 7,700 patients living in the area of Wolverhampton. The practice is situated within an area of very high deprivation. The practice is a purpose built single storey building and provides on-site parking.

The team of clinical staff at the practice is made up of one GP partner and two salaried GPs (all male), one practice nurse and two healthcare assistants (all female). A business manager (non-clinical partner), reception and administrative staff provide management and administration support for the practice.

The practice is open between 8am and 6.30pm Monday, Tuesday, Thursday and Friday. On Wednesday the practice is open between 8am and 1pm and extended hours are available on Tuesday evening between the hours of 6.30pm and 8.30pm. Patients can book appointments in person, on-line or by telephone. Appointments are from 9.30am to 12.30pm every morning and afternoon surgery 4pm to 6pm on Monday, Thursday and Friday. Appointments are available with the practice nurse from 9am to 1pm and 2pm to 5.30pm daily with the exception of Wednesday afternoon.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. Services provided at Low Hill Medical Centre include the following clinics; asthma, family planning, new patient medical health checks, diabetic, baby vaccination and wellbeing screening clinics and drug and alcohol services.

The practice has opted out of providing out of hours services to their own patients. Primecare provides an out of hours service for patients between 8am and 9am Monday to Friday. At all other times when the practice is closed patients are asked to contact the NHS 111 service.

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

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.

Detailed findings

How we carried out this inspection

Before our inspection we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We asked NHS England, Wolverhampton CCG and the local Healthwatch to tell us what they knew about the Low Hill Medical Centre branch of MGS Medical Practice and the services they provided. We reviewed information we received from the practice prior to the inspection. The information we received did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 27 May 2015. During our visit we spoke with a range of staff including GPs, business manager, practice nurse and reception and administration staff. We spoke with eight patients which included one member of the patient participation group (PPG) who used the service. We observed how patients were being cared for and talked with carers and/or family members. We reviewed surveys and comment cards where patients 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 are provided for specific groups of people and what good care looks 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)

Good

Are services safe?

Our findings

Safe track record

Three practices had recently merged to form MGS Medical Practice. The practice showed us a folder which contained records of incidents. The folder held records of incidents that had occurred at the three practices since 2010. The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example it had been incorrectly recorded in a patient's notes that they had a screening test carried out. This was appropriately followed up, all records were corrected and the patient contacted and reassured. The importance of accurate documentation was discussed with staff at a practice meeting.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these over this period and could show evidence of a safe track record for this time. However we were made aware by patients of similar incidents that had occurred related to medicine errors. We found that these incidents had not been investigated by the practice to ensure that measures were put in place to prevent reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff showed us the system used to manage and monitor incidents. They told us that they completed incident forms which were passed to the business manager. Staff said that problems were dealt with immediately and then discussed at quarterly practice meetings or at the weekly protected learning time sessions. If staff could not attend the meetings which included locum staff working at the practice, one to one discussions and feedback was provided. Staff also told us that if they could not attend the meetings they would read the minutes. We reviewed copies of the minutes of meetings which confirmed discussion of incidents had taken place.

We saw that significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We saw that significant events were followed up and referred or shared with other professional agencies outside the practice where appropriate. The local Clinical Commissioning Group (CCG) who monitored the performance of the practice told us that they did not have any safety concerns about this practice. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We asked the practice to submit a summary of significant events for the previous 12 months before our inspection date. We did this to review the incidents, to look for common themes and to help decide if learning from events was evident. We received a summary of ten significant events which had occurred between June and September 2014. We reviewed the records which showed incidents related to information technology, medication, patient treatment and communication were reviewed. We saw that these were discussed and appropriate and timely action had been taken to manage incidents that may affect patients' safety. We saw evidence of learning following significant events. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. For example, due to poor communication two doses of the same vaccine (in different forms) were administered to the same patient within the same period. This was followed up with the public health immunisation team and a report of the incident completed. Parents were reassured and advised of action to take if any they had any concerns. Discussions were held with practice staff and systems were put into place to improve communication with community services.

The lead GP was responsible for disseminating safety alerts and there were systems in place to ensure they were acted on. The GP looked at the key messages in the alert and then disseminated these to relevant staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received

relevant role specific training on safeguarding. We asked members of the medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware of who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Practice staff told us when they received accident and emergency (A&E) discharge letters that they were reviewed by a GP. This included identifying and reviewing vulnerable adults and children with a high number of A&E attendances. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. We saw an example of this when the nurse contacted the health visiting team to discuss children who had not attended for their immunisations.

There was a chaperone policy, which was visible on the waiting room noticeboard, in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff, including health care assistants had been trained to be a chaperone. Reception staff acted as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

Medicines management

We checked the medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

A log of the fridges' temperature ranges had been recorded twice daily which demonstrated that vaccines in the fridges were stored in line with the manufacturers' guidelines. The medicine management policy also described the action to take if vaccines had not been stored within the appropriate temperature range. Practice staff we spoke with understood why and how to follow the procedures identified in the policy.

The practice nurse and healthcare assistant administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurse and healthcare assistant had received appropriate training to administer vaccines.

We saw records of audits that identified best practice actions to be taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing for various illnesses that patients presented with. Action taken following the medicines audits included ensuring that all clinicians had access to a copy of the local prescribing guidelines and evidenced change in prescribing habits in line with the guidelines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. The protocol complied with the legal framework and covered all required areas. For example, how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat medicines were appropriate

and necessary. We saw that prescription pads and paper for printing prescriptions were stored in locked cupboards and that blank prescription forms were handled in accordance with national guidance. For example, a system was in place to record serial numbers of the forms received and issued. Systems were in place to ensure that GP prescription pads used for home visits were tracked through the practice.

Cleanliness and infection control

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

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Staff described how they would use these to comply with the practice's infection control policy. For example when dealing with spills of blood or bodily fluids. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Staff told us that they were aware of the policies and where to find them if they needed to refer to them. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Information received from the practice manager following the inspection informed us that the practice nurse was the lead for infection control. All staff had received training about infection prevention and control specific to their role. We saw evidence that daily infection control checks were carried out by all staff. Minutes of practice meetings showed infection control was an ongoing item on the agenda.

The practice had procedures in place to protect staff and patients from the risks of health care associated infections. We saw records that demonstrated that clinical staff had received the relevant immunisations and support to manage these risks. The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw records that demonstrated all portable electrical equipment had been tested in July 2014 to ensure they were safe to use. We saw records that demonstrated that all medical equipment had been calibrated in April 2015 to ensure the information they provided was accurate. This included devices such as weighing scales and blood pressure measuring devices.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The staff rota showed that there was a reliance on the use of regular locum GPs. The practice used the same locum GPs and were advertising to fill the GP vacancies. We saw that the practice employed more healthcare assistants than practice nurses. This restricted the level of support, care and treatment that could be offered to patients. For example this impacted on the availability of appointments for patients and treatments provided at evening clinics. The practice nurses provided 20 hours per week to cover the three practices. We saw that there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Good

Are services safe?

There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts and were made aware that they would be working across all three practices.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We saw records that demonstrated regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice had a risk assessment policy this identified risks related to the practice. The practice had completed a risk assessment table where specific risks related to the practice were documented. We saw that each risk was rated and mitigating actions recorded to reduce and manage the risk. We saw that where risks were identified that action plans had been put in place to address these. Each risk was assessed and rated using a risk assessment tool and mitigating actions recorded to reduce and manage the risk. Risks associated with the service and staffing changes (both planned and unplanned) were included in the risk assessment. For example these included fire risk assessments and safety of medical electrical equipment. The meeting minutes we reviewed showed risks were discussed at practice meetings.

There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. We saw an example of this at the time of our inspection where the practice nurse discussed a child who had not attended their vaccination appointment with the immunisation service. A further incident involved another child who was referred to hospital immediately due to a rapid deterioration in their health. Staff we spoke with told us that children were always provided with an on the day appointment if required.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. Signs were visible in the practice to ensure patients and visitors were aware that oxygen was in the building with details of the precautions they needed to observe.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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 and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, the contact details of the heating company to be contacted if the heating system failed. The plan was last reviewed in April 2015.

The practice had carried out a fire risk assessment in April 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). For example, the GP partner described how they had used the NICE guidelines for the management of patients with diabetes and asthma. We saw that the GPs, nurses and healthcare assistants used clinical templates in the management of patients care and treatment. This assisted the staff to assess the needs of patients with long-term conditions and older patients for example. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurse that thorough assessments of patients' needs in line with NICE guidelines were completed and these were reviewed when appropriate.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with the national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD) were being referred to other services when required. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Feedback from patients confirmed they were referred to other services or hospital when required.

The lead GP told us that a member of the medicines optimisation team from the clinical commissioning group (CCG) attended the practice regularly. This was to provide advice and check that patients had received medicines that were appropriate and there were no unusual patterns of prescribing. We looked at national data from the National Health Service Business Authority (NHSBA) for 2013 - 2014 and saw that prescribing levels for antibiotics and hypnotic (sleeping tablets) medicines were in the expected range.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the business manager to support the practice to carry out clinical audits.

The practice showed us summaries of eleven audits that had been undertaken in the last 12 months. We saw that four of these indicated that they were completed audit cycles where the practice was able to demonstrate the changes resulting since the initial audit. These four audits were all linked to the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. These audits had been carried out to validate the accuracy of QOF related information. For example a review of patients with learning disabilities resulted in an increase of patients appropriately diagnosed and recorded from 46 to 76. All new patients identified were invited for health checks with the practice team and community learning disability team. The practice had plans in place to complete four clinical audits. These included an audit of the medicines used to treat patients with respiratory problems and an audit of whether patients diagnosed with atrial fibrillation (AF), a heart condition that causes an irregular and often abnormally fast heart rate were assessed for the risk of a stroke and are treated in line with national guidance.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example 93.1% of patients with asthma, 92.3% of patients with diabetes and 82.4% experiencing poor mental health had received an annual review. These results were above or

Good

Are services effective?

(for example, treatment is effective)

in line with the national average. The practice told us that there were 76 patients with a learning disability registered with the practice and staff were in the process of ensuring that all these patients had an agreed care plan in place.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice was less proactive in ensuring that systems were in place to ensure that patients with end of life care needs received the right care, in the right place at the right time. We saw there was a system in place that identified patients at the end of their life and staff at the practice told us that they had nine patients on the palliative care register. There were alerts within the clinical computer system making clinical staff aware of their additional needs. However the practice had not held multidisciplinary meetings with other professionals involved in their care. The GP partner and business manager told us that multi-disciplinary working between the practice, district and palliative care nurses took place on an adhoc and informal basis to support these vulnerable patients. These were in the form of occasional telephone discussions with no information to confirm what was discussed and agreed. The partners told us that they ha plans to re-establish regular formal meetings.

The practice participated in local benchmarking run by the Clinical Commissioning Group (CCG). The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data highlighted areas where the practice was performing well and areas they needed to improve. For example, the minutes of a meeting we looked at showed that the CCG had identified that the practice needed to make improvements in the care of patients diagnosed with cancer. The minutes showed that the practice had acknowledged and agreed to put plans in place to action this.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that clinical and non-clinical staff were up to date with attending mandatory courses such as basic life support.

All the GPs we spoke with were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

The practice nurses were expected to perform defined duties and had extended roles. The practice nurses were able to demonstrate that they were trained to fulfil these duties. For example, practice nurses had additional qualifications in asthma, diabetes, prescribing, administration of childhood immunisations and cervical screening. We saw training records to confirm that staff had received training appropriate to their role.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All the staff we spoke with understood their roles and felt the system in place worked well.

The lead GP told us that formal multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs were not held. We were shown the minutes of meetings held with other

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Are services effective?

(for example, treatment is effective)

professionals outside of the practice however these did not confirm the level to which these patients were discussed. They told us that they had plans to re-establish formal meetings.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence that the practice had used significant events to learn and improve information sharing between the practice and other providers.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw there was a MCA (2005) policy in place to support staff in making decisions when capacity was an issue for a patient. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us that approximately 86% of these care plans had been reviewed in the last year. When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

Patients over 75 years of age had a named GP to provide continuity of care. Childhood vaccinations and child development checks were offered in line with the Healthy Child Programme. We saw data that demonstrated the practice was in line with the regional CCG average in the uptake of childhood immunisations

There were systems in place to support the early identification of cancers. The practice carried out cervical screening for women between the ages of 25 and 64 years. We saw that the practice's performance for cervical smear uptake was 84.8% which was above the national average. Public Health England National data showed that the practice was less proactive in screening for cancers such as bowel and breast cancer. The practice was aware of this and had discussed this underperformance with the local CCG in February 2015. The practice made a commitment to investigate this and identify actions for improvement.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The healthcare assistant actively engaged patients in lifestyle programmes. The practice had performed better than other practices in the local CCG area for monitoring and supporting patients who smoked. Information showed that 86.9% of patients had their smoking status recorded and 74.2% of these patients had accepted support to help them stop smoking. We were told that patients were sign posted to weight loss clinics and exercise referrals made to support those who needed to manage their weight.

We saw that up to date health promotion information was displayed, available and easily accessible to patients in the waiting area of the practice. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations which included vaccinations for older patients was above average for the local Clinical Commissioning Group (CCG). There was a clear policy for following up non-attenders.

Good

Are services effective?

(for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice provided a service to patients who misused substances and to patients in prison. The practice worked with local community services to support the care and treatment provided to these patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015. The survey included responses collected during January to March 2014 and July to September 2014. There were 449 survey forms sent out of which 109 responses were returned.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated in line with others for patients who rated the practice as good or very good. The practice was also average for its satisfaction scores on consultations with GPs and nurses. For example:

- 86% said the GP was good at listening to them compared to the CCG average of 84% and national average of 88%.
- 87% said the GP gave them enough time compared to the CCG average of 84% and national average of 86%.
- 83% said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 93%.
- 92% said they found the receptionists at the practice helpful compared to the CCG and national averages of 87%.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 49 completed cards. The cards contained mixed comments about the practice and staff. Comments made said that it was difficult to gain an urgent appointment, patients expressed concerns about the merging of the practice and the lack of continuity of GPs. Patients also commented that they were treated with dignity and respect and that they were more than happy with the standard of care they received. We also spoke with eight patients on the day of our inspection their comments were in line with the comments made in the cards we received.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The position of the open reception desk within the waiting room made it difficult for confidential conversations to take place. Reception staff that we spoke with were aware of the difficulties. Systems were in place to maintain patient's confidentiality. These included taking patients to a private room to continue a private conversation and transferring confidential telephone calls to a private room if a person rang the practice for investigation results.

We saw that staff had received training in equality and diversity and that there was a policy for them to refer to. Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the business manager. The business manager told us they would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception area and on the practice web site stating the practice's zero tolerance for abusive behaviour. Receptionists could refer to this to help them to manage potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 84% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and national average of 82%.
- 80% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73% and national average of 75%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment

Good

Are services caring?

they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. This enabled them to be involved in decisions about their care. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 83% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 83%.
- 83% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 71% and national average of 67%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff were kind, understanding and helpful.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a 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. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice provided a service for patients who experienced problems with alcohol and drug misuse. The lead GP provided this service together with staff from Wolverhampton alcohol and drug rehabilitation services. Patients did not have to be registered with the practice; all appointments are made directly with the drug rehabilitation team.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The CCG are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example discussions had been held to open up the waiting area at Low Hill Centre.

The practice nurse told us that the practice offered longer appointments for those who needed them. This included patients undertaking spirometry (lung function) tests and those attending reviews for long-term conditions, for example, diabetes. Appointments were offered outside working and school hours which benefited patients who worked and younger patients.

MGS Medical Practice had worked closely with the local CCG during the process of merging the three practices.

We spoke with a member of the patient participation group (PPG) about the interaction between the practice and PPG. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The PPG was a small group, consisting of four patient representatives. Regular formal PPG meetings were not currently held. However the four members had been actively involved in ensuring that the needs of patients were considered during the merger of the three practices.

The PPG member told us that the practice had responded to ideas that had been suggested by the PPG. For example, discussions had been held with the CCG to progress plans to extend the waiting area to provide improved access for patients.

We saw that there was a psychologist attached to this practice who provided support for patients who experienced poor mental health.

Tackling inequity and promoting equality

The practice provided equality and diversity training for all staff and we saw evidence that staff had last completed this training in 2014. Staff we spoke with confirmed that they had completed equality and diversity training.

The practice recognised the needs of different groups in the planning of its services. The practice was situated on the ground floor of the building. Although at times the waiting area was very busy, it was able to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. Facilities for patients with mobility difficulties included designated car parking spaces and adapted toilet facilities. A hearing loop for patients with a hearing impairment was available.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The practice had recognised the needs of different groups in the planning of its services. For example, patients over 75 years of age and had a named GP to ensure continuity of care. Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records, for example patients who had health problems related to the misuse of alcohol and/or drugs.

Access to the service

The practice was open between 8am and 6.30pm Monday, Tuesday, Thursday and Friday. On Wednesdays the practice was open between 8am and 1pm and extended hours were

Good

Are services responsive to people's needs?

(for example, to feedback?)

available on Tuesday evenings between the hours of 6.30pm and 8.30pm. Patients could book appointments in person, on-line or by telephone. Appointments were available from 9.30am to 12.30pm every morning and afternoon surgery 4pm to 6pm on Monday, Thursday and Friday. Appointments were available with the practice nurse from 9am to 1pm and 2pm to 5.30pm daily with the exception of Wednesday afternoons.

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

Longer appointments were available for older patients, children, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions.

The patient survey information we reviewed for January 2015 showed patients provided mixed responses to questions about access to appointments and generally rated the practice well in these areas. For example:

- 78% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 74%.
- 73% said they usually waited 15 minutes or less after their appointment time compared to the CCG and national average of 66%.
- 64% described their experience of making an appointment as good compared to the CCG average of 72% and national average of 74%.
- 62% said they could get through easily to the surgery by telephone compared to the CCG average of 65% and national average of 72%.

The patient views in the 49 comments cards we received were mixed. Some of the patients comment cards mentioned that making appointments by telephone was difficult. Patients commented that they could not always book the appointment they wanted. Patients told us that it was difficult to get an urgent appointment and that they sometimes had to wait up to three weeks for a routine appointment. This was confirmed by the patients we spoke with. We saw an action plan had been formulated to address comments made by patients. These included addressing patients concerns about appointments by employing an additional GP and undertaking a review of the skill mix of staff. Some patients we spoke with and comments in some of the comment cards told us they had no problems when making appointments.

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. We saw that there was information on the practice website and a poster in the waiting room informed patients how to complain.

We looked at seven complaints the practice had received for the period 20 January 2014 and 4 March 2015. We saw they had been responded to and dealt with in a timely manner and found the practice demonstrated openness and transparency when dealing with complaints. We saw practice meeting minutes that demonstrated complaints were discussed and learning from them was shared with staff. This supported staff to learn and contribute to any improvement action that might have been required. We saw that lessons learned from individual complaints had been acted on.

Information contained in the complaint summary showed that an investigation had been carried out, that response letters had been sent to patients, any trends to the complaints had been identified and the issues were discussed with staff involved. The report contained brief details of the complaint, the outcome, action to be taken to prevent reoccurrence, which included a review of clinical practice and policies and procedures where required. The report also detailed the learning shared with all staff. We saw practice meeting minutes that demonstrated complaints were a regular agenda item. This supported staff to learn and contribute to any improvement action that might have been required.

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 deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were displayed on the practice website, in the waiting areas and in staff areas. The practice vision and values included to provide local people with good clinical care locally delivered; to deliver a quality service to all patients and to have competent staff to carry out treatments at all times; to encourage patients to communicate with them on the services offered through the patient participation group, communication and surveys and to be a learning organisation that continually improves the services offered to patients.

We spoke with nine members of staff. We found that most of the staff knew and understood the vision and values for the development of the practice. Staff knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of meetings held at the practice and saw that staff had discussed and agreed the vision and values for the practice. However we also found that some staff had experienced difficulties with the recent merger of the three practices. The GP partner and business manager were implementing systems to manage the situation.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in folders, on the desktop on any computer within the practice. We looked at five of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All five policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice showed that they had achieved 90.2% of the points available compared with a national value of 94%. We saw that QOF data was regularly discussed at monthly meetings. We saw that actions had been taken to maintain or improve patient outcomes. The main concerns for the practice were related to the merger of the three practices into one that had highlighted errors in data input. The practice had started to address this.

The practice had recently put in place a programme of clinical audits to monitor quality and systems to identify where action should be taken. Audits previously carried out were related to the validation of QOF information and not specifically clinical audit. These were undertaken to create one database of patients from the registers of the practices that had been merged. For example the practice carried out a validation of the children safeguarding registers. This identified the number of children on the practice at risk registers, children identified as no longer on the registers were removed and appropriate contact and alert details added. The practice had commenced collating data on six planned clinical audits. One example of these was an audit of patients diagnosed with diabetes so that the practice could assess their performance against national standards.

Evidence from other data sources, including incidents and complaints were used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice had signed up to submit governance and performance data to the CCG.

The practice had arrangements for identifying, recording and managing risks. The business manager showed us the risk log, which addressed a wide range of potential issues, for example loss of the computer system. We saw that the risk log was regularly discussed at meetings and updated in a timely way. Risk assessments had been carried out where

Are services well-led?

Good

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

risks were identified and action plans had been produced and implemented. In the event of the loss of the main computer operating system, practice staff had identified alternative computers and installed a back-up computer system to allow staff to access patient information and guidelines.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed.

The business manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example grievance, health and safety, induction policy, equality which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

Following the recent merger of the three practices some senior staff had concerns about how the practice was managed. Some staff told us that there was not an open culture within the practice and the opportunity to raise issues at practice meetings was not available to them. We found that these concerns were being managed appropriately by the management team at the practice and other external organisations. We found that the minutes of meetings we reviewed and conversations with the majority of staff, a member of the PPG and some patients demonstrated that there were opportunities to raise concerns openly.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, friends and family test, compliments and complaints received and a suggestion box. We also looked at the results of the practice survey for December 2014 and saw appropriate action was taken to address comments and suggestions made by patients. Although not fully formed the practice had a small but active patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice PPG consisted of four members; there was a representative from each of the practices that had merged. All of the members were female and meetings were held individually with the business manager and lead GP or as often as possible as a group to discuss patient feedback and improvements needed at the practice. We saw an action plan had been formulated to address comments made by patients. These included addressing patients concerns about appointments by employing an additional GP and undertaking a review of the skill mix of staff.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We were told that the practice was actively looking for specific training to support the work of the healthcare assistants. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had monthly protected learning time.

The practice told us that they had plans to become a training practice for GP registrars (qualified doctors who undertake additional specialist training to gain experience and higher qualification in General Practice and family medicine) in the future. The practice was preparing themselves for this as part of their plans following the merger of the three practices.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We saw minutes that confirmed this.