Merstow Green Medical Practice

Inspection report

Merstow Green
Evesham
Worcestershire
WR11 4BS
Tel: 01386 765600
www.merstowgreenmedicalpractice.co.uk

Date of inspection visit: 7 Nov to 7 Nov
Date of publication: 19/12/2018

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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous rating September 2015 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Merstow Green Medical Practice on 7 November 2018 as part of our inspection programme.

At this inspection we found:

- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes in order to prevent a recurrence.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines and best practice.
- We saw that staff involved and treated patients with compassion, kindness, dignity and respect.
- There was a Practice Liaison Manager who acted as the interface between patients and staff.
- The practice continued to organise IT training and support sessions to train patients to use the practice's on-line systems, for example, how to book appointments.
- The most vulnerable patients (for example, those with learning difficulties or those with severe health needs) were given a medical alert card which gave an ex-directory telephone number for the patient (or someone assisting the patient) to contact the practice.
- The nurse manager was the clinical care co-ordinator, whose responsibilities included drawing up clinical care plans for patients who would benefit from a personalised plan.
- The practice took part in local pilot projects, including Active Monitoring for patients with mental health issues.
- The practice achieved maximum points in the Quality and Outcomes Framework for 2017/18.
- Patient feedback on the level of care and treatment delivered by all staff was very positive.
- Although the appointment system had been changed as a result of patient feedback, not all patients found the appointment system easy to use.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- There were strong links with local organisations which raised awareness of the support services available in the local area.
- A new salaried GP started a urogynaecology service in June 2018.

The areas where the provider **should** make improvements are:

- Strengthen the audit programme to include more second cycle audits and more emphasis on learning from audit findings.
- Continue to monitor and act on the results of patient surveys in order to meet the needs of the patient population.
- Track prescriptions throughout the practice.
- Monitor expiry dates for medicines if the maximum refrigerator temperature exceeds the recommended maximum.
- Check that consulting room doors are locked when not in use for security purposes.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist advisor, a practice nurse specialist advisor and a member of the CQC medicines team.

Background to Merstow Green Medical Practice

Merstow Green Medical Practice is situated in a modern purpose built medical centre in Evesham, Worcestershire. The building is shared with Abbey Medical Practice, Community Services, and attached staff. Merstow Green Medical Practice is registered with the Care Quality Commission (CQC) as a partnership provider to deliver the following Regulated Activities: diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury. The surgery holds a General Medical Services (GMS) contract with NHS England. The GMS contract is a contract agreed nationally between general practices and NHS England for primary care services to local communities. At the time of our inspection, Merstow Green Medical Practice was providing medical care to 10,315 patients.

The practice provides dispensing services to those patients who live more than one mile away (1.6 kilometres) from their nearest pharmacy (40% of the practice population).

The practice provides additional GP services commissioned by South Worcestershire clinical commissioning group (CCG). For example, minor surgery. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

Parking bays for disabled patients are located adjacent to the building. Other patients can use the public car park which is a few minutes' walk from the practice. All consulting rooms are located on the ground floor, with administrative staff located on the first floor. There are facilities for disabled patients which include automatic entrance doors and a low-rise reception counter.

Information published by Public Health England rates the level of deprivation within the practice population group as six, on a scale of one to ten, where ten is the least deprived.

There are four GP partners (two male, two female) and three salaried GPs (one male, two female). At the time of our inspection a locum GP was providing cover for a GP partner who was on maternity leave. The GPs are supported by the practice manager, a clinical pharmacist, a nurse manager, two nurse practitioners, two practice nurses, three health care assistants, a dispensing team and a reception and administrative team.

Please see the evidence table for details of the opening hours and extended hours provision.

When the practice is closed, there is a recorded message giving details of the out of hours service.

Information about the practice is available to download from their website:

www.merstowgreenmedicalpractice.co.uk

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. We noted that multi-disciplinary safeguarding meetings were held every two weeks and that discussions were minuted.
- It was practice policy that only health care assistants acted as chaperones. They were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control (IPC). We saw that IPC audits were carried out annually.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with most medical emergencies and staff were suitably trained in emergency procedures. One emergency medicine was out of date; the practice had not been able to replace it due to national stock shortages and had not risk assessed the situation or sought an alternative. A significant event was raised immediately this was pointed out and an alternative medicine was sourced after consultation with the practice pharmacist.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. We saw evidence of a co-ordinated approach between the practice and external agencies, such as district nurses and the health visitor to support the provision of safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks. We noted that the maximum temperature in one of the dispensary refrigerators had exceeded the recommended maximum for a medicine which was stored there; this reduced the expiry date to 28 days. We were told that staff monitored refrigerator temperatures in accordance with Standard Operating Procedures and saw that logs were kept.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.

Good

Are services safe?

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- Arrangements for dispensing medicines at the practice kept patients safe.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services .

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or might be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of their medicines.
- Patients in this cohort who were assessed as needing a personalised care plan were reviewed at monthly multi-disciplinary meetings as a minimum and were given a contact card with details of the Clinical Care Co-ordinator.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice's performance on quality indicators for long term conditions was in line with local and national averages.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%.
- The Practice Liaison Manager followed up failed attendance of children's appointments in the practice or in secondary care or for immunisation.

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

- The practice's published uptake for cervical screening was 72%, which, although in line with the local and national average, was below the 80% coverage target for the national screening programme. The practice provided evidence from Public Health England to show that the uptake had improved to 81%, which staff said was a direct result of staff telephoning eligible patients and encouraging them to attend, as well as the provision of additional clinics out of core hours and at weekends.
- The practice's uptake for breast and bowel cancer screening was in line with the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

Good

Are services effective?

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The practice's performance on quality indicators for mental health was in line with or above local and national averages. For example, 97% of patients with dementia had had a face to face review in the preceding 12 months compared to the local and national averages of 83%.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- The practice achieved the maximum points available for the Quality and Outcomes Framework (QOF) 2017/18.
- There were some instances of high exception reporting, which we found to be the result of read coding issues (exception reporting is the removal of patients from QOF calculations where, for example, patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). For example, chronic lung disease exception reporting for spirometry tests was 29%, which was 22% above the local average and 21% above the national average. The practice explained that they did not enter results of spirometry tests carried out in hospitals. Exception reporting for patients with a new diagnosis of dementia was 42%, which was 8% above the local average and 20% above the national average. The high percentage was due to the fact that blood tests were done before patients were referred for assessment and the delay in being seen meant that formal diagnosis was delayed beyond the QOF window.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice had appointed a Patient Liaison Manager who was the interface between patients and staff. The

Good

Are services effective?

Patient Liaison Manager signposted patients to appropriate services within the practice and in the local area and was responsible for training and supporting the Patient Liaison Team in their work.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who might be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.
- We received 10 comment cards which had been completed by patients. Patients wrote that staff were caring and compassionate.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available. Patients who had hearing impairments were given a hearing alert card which authorised the patient to be able to book a double appointment with their responsible GP or clinician at a time and day that is convenient to both themselves and their responsible GP. The card also gave the patient the details of a generic email address for their use only. A Deaf Direct interpreter could be arranged if required.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practice's GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. Patient needs and preferences were taken into consideration.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone GP consultations were available which was helpful for patients who were unable to attend the practice during core working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice provided dispensary services for people who needed additional support with their medicines, for example a delivery service, weekly or monthly blister packs, large print labels.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.
- There was a medicines delivery service for housebound patients.

People with long-term conditions:

- The nurse manager was the clinical care co-ordinator for patients with long term conditions.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and telephone consultations.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- A member of the patient participation group had helped with a 'walk-through' of the premises to raise awareness of the issues faced by patients with dementia when they attended for appointments.
- The practice took part in an early intervention pilot project, launched by Springfield Mind, to support patients with mental health issues. Active Monitoring was a self-directed psycho-educational programme of

six face to face sessions over an eight week period. Two Mind practitioners each attended the practice for a session once a week. Patients were referred by a clinician. We were told that 192 patients had been referred since the project began in 2017. 84% of those accessing the service for depression improved, 100% of those accessing the service for anxiety improved and 84% noted an improvement in their overall wellbeing. One patient who had attended 36 appointments for depression and anxiety in the six months prior to being referred to Active Monitoring only attended eight appointments after the course for conditions unrelated to mental health issues.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was becoming easier to use since the changes were introduced.
- The practice's GP patient survey results were below local and national averages for questions relating to access to care and treatment. The practice was aware of patient dissatisfaction with regard to access and introduced a telephone consultation service in May 2018, which was after the national survey was conducted. The results from the practice's in-house survey, conducted in June 2018, indicated that patient satisfaction was improving in this area (27 out of 33 patients said that the new appointment system was either very good or fairly good).

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints. An analysis of trends was carried out quarterly. The practice acted as a result to improve the quality of care. For example, a GP telephone consultation service was launched in May 2018 as a result of negative patient feedback about access to appointments.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

The GP partners and practice management team had the capacity and skills to deliver high-quality, sustainable care.

- The partners and management team were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Managers at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, three nurses were due to retire and succession plans had been agreed.
- Key areas of responsibility were devolved amongst the GP partners, clinical staff and the management team.

Vision and strategy

The practice had a clear vision and strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a strategy and supporting business plans to achieve priorities. Business meetings, attended by the GP partners and practice manager, were held monthly.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- The GP partners and management team acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- Staff commented on the positive relationships between the teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Policies and procedures were embedded to ensure safety and they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.

Good

Are services well-led?

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had a business continuity plan and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was a virtual patient participation group (PPG) and we noted that the practice was actively recruiting additional members who would be prepared to attend regular meetings.
- The service was transparent, collaborative and open with stakeholders about performance.
- A GP was the locality Alliance lead, so the practice was kept informed of developments and issues in the local area.
- The practice regularly promoted NHS campaigns within the practice. For example, staff took part in the 'Wear It Pink' day to raise awareness of breast cancer and they wore jeans to support 'Genes for Jeans' and raise awareness of children with genetic disorders.
- Staff walked 14 miles along the Severn Valley Way to help raise funds for a local hospice.
- Members of local organisations such as Marie Curie and the Worcestershire chronic lung disease team organised stands in reception to raise awareness of their work.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- The practice was keen to develop new services for patients. For example, micro suction (the removal of excess ear wax from inside the ear canal) was due to be provided for patients at the end of November 2018 and the practice planned to extend this to patients from other practices in the locality. Urogynaecology was carried out by a new salaried GP. We were told that 49 patients had benefitted from the urogynaecology service since it started in June 2018 and that the practice intended to extend the service to patients from the locality in the future.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.