Dronfield Medical Practice

Inspection report

Dronfield Medical Centre
High Street
Dronfield
Derbyshire
S18 1PY
Tel: 01246 412242
www.dronfieldhealth.co.uk

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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 location	Good
Are services safe?	Requires improvement
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.

The key questions at this inspection are rated as:

Are services safe? – Requires improvement

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 Dronfield Medical Practice on 30 October 2018. The inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions to check whether the provider was 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.

At this inspection we found:

- Patients provided positive feedback about the care they had received, and this was supported by findings from external and internal surveys and patient comment cards.
- The practice opened a 'pool' appointment system from 10am each weekday morning so that any patient who had been triaged and needed an appointment, or felt they needed to be seen that day, could attend and see either a GP or the nurse practitioner.
- Pre-booked appointments were allocated for 15 minutes in the morning session, and 12 minutes in the afternoon. This recognised that the practice's higher numbers of patients aged 65 and over often had more complex needs. It also enabled clinicians to be less pressured by allowing them more time to consult effectively.
- The provider achieved 99.5% in the 2017-18 Quality and Outcomes Framework (QOF), which was in line with the previous year's total. This was in alignment with local averages and slightly above the national average.
- We found effective systems were in place to promote adult and child safeguarding.
- Immunisation and cancer screening rates were high and exceeded local and national averages.
- The practice team reviewed significant events, including positive ones, to learn and share best practice. If a patient was involved in an adverse incident, they would receive an explanation as part of the duty of candour.
- The monitoring and recording of temperatures in the practice's vaccine refrigerators were not always being undertaken in line with guidance. The practice took immediate action to address this matter when we brought this to their attention.
- Environmental risk assessments had been undertaken, including fire and Legionella.
- The practice ensured that care and treatment was delivered according to evidence-based guidelines.
- The practice encouraged learning and improvement, and we saw that staff were up to date with the practice's training schedule. As a training practice, there was an emphasis on continual learning and there were mechanisms in place to support this including weekly clinical meetings, daily clinicians' 'huddles' to discuss any cases of interest and proposed referrals, debrief discussions, and an established clinical audit programme.
- We found an open and supportive culture within the practice. Staff felt valued and told us they found the GPs and the practice manager to be accessible and approachable.
- The practice had established strong links with their community and had engaged in events to support local services and to promote healthy lifestyles to benefit the wider community.

Importantly, the provider **must** make improvements to the following areas of practice:

- Ensure care and treatment is provided in a safe way to patients. The monitoring of vaccine refrigerators must be maintained in line with guidance, supported by appropriate documentation, with appropriate action taken in the event of any arising concerns.

There were also some areas where the provider **should** make improvements:

- The infection control lead should attend some additional training to support their 'lead' role.
- The practice should consider formal recording of regular oxygen cylinder checks.
- The practice should review their complaints procedure to ensure this accurately reflects guidance.

Overall summary

Professor Steve Field CBE FRCP FFPH FRCGP
Chief 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 CQC inspector supported by a GP Specialist Advisor.

Background to Dronfield Medical Practice

Dronfield Medical Practice is registered as a location with the CQC, with the provider being a partnership consisting of three GPs (two males and one female).

Dronfield Medical Practice received a previous CQC inspection in October 2014. At that inspection, it received an overall good rating. The full comprehensive report for this inspection can be found by selecting the 'all reports' link for Dronfield Medical Practice on our website at

The practice is situated in Dronfield, which is a town in North-East Derbyshire between Chesterfield and Sheffield. The surgery moved into the purpose-built premises in 2008 and is co-located with a number of community-based health services within a two-storey building. It provides primary care medical services commissioned by NHS North Derbyshire CCG and NHS England.

The practice has slightly over 10,000 registered patients. Patients are predominantly of white British origin, with only 1.7% of people within the practice area being from black and minority ethnic (BME) groups. The age profile of registered patients shows a higher percentage of patients aged over 65 compared to the national average at 24.1% compared to 17.1%. The age profile is generally in line with CCG averages. The practice serves a population that is ranked in the least deprived decile for deprivation, and has lower levels of unemployment compared to averages.

There are 25 staff based at Dronfield Medical Practice. In addition to the three GP partners, there are five salaried GPs (four females and one male) working at the practice.

The nursing team consists of an advanced nurse practitioner, two practice nurses, a healthcare assistant and a phlebotomist.

The clinical team are supported by a practice manager and a team of 11 staff who provide reception, administrative and secretarial support.

Dronfield Medical Practice is an established training practice. It accommodates GP registrars and medical students, as well as supporting placements for student nurses and pharmacy trainees.

The practice opens from 8am until 6.30pm Monday to Friday, with extended hours opening on a Saturday morning between 9am-11.30am for pre-booked appointments. Patients can also obtain late weekday appointments and weekend appointments through a recently introduced extended access services provided at two nearby local GP practices.

The surgery closes for one afternoon each month for staff training. When the practice is closed, patients are directed to Derbyshire Health United (DHU) out of hours via the 111-service.

Requires improvement

Are services safe?

We rated the practice as requires improvement 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. Staff had received up-to-date safeguarding training appropriate to their role. They knew how to identify and report safeguarding concerns.
- Staff who acted as chaperones were trained for their role and had received a 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.
- 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 adequate 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. Locum GPs were rarely used.
- There was an effective induction system for staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- 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.

Information to deliver safe care and treatment

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

- The information needed to deliver safe care and treatment was available to staff. There was a clear process for managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice mostly had reliable systems for appropriate and safe handling of medicines, but the oversight of vaccine management required improvement.

- The systems for managing and storing medicines and emergency medicines and equipment, mostly minimised risks. However, we found that the procedure for monitoring vaccine refrigerator temperatures was not robust, and therefore at the time of our inspection, the practice was not able to provide sufficient assurance that the cold chain had not been breached. The practice sought advice from Public Health England (PHE) after our inspection and took immediate steps to rectify the situation. PHE determined that they were provided with additional information by the practice to satisfy them that there had not been a breach in the cold chain and therefore vaccines had been stored appropriately prior to their administration. The practice commenced a root cause analysis investigation at PHE's request to review what had contributed to this situation to ensure effective learning could be applied.
- The oxygen cylinder was checked to ensure supplies were available if required, but there was no formal documentation of the checks being dated and recorded.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The prescribing of broad spectrum antibiotics at the practice was slightly higher than CCG and national averages but the practice was aware of this issue and could explain their rationale for this. They were monitoring this with input from their medicines management team.
- 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.

Requires improvement

Are services safe?

- There was a robust monitoring process for patients prescribed high-risk medicines.
- The practice had established effective links with the medicines management team who attended the practice regularly, and formal meetings were held twice a year to review performance.

Track record on safety

- There were risk assessments available in relation to safety issues.

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. GPs and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong and were reported. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. Learning was discussed at meetings and disseminated to the practice team. Positive events were also used for learning.
- The practice acted on patient and medicine safety alerts. If patients were found to be potentially affected by the alert, they were reviewed to ensure they were kept safe.

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.

Please note: Any Quality Outcomes (QOF) data in the evidence table relates to 2016/17, unless otherwise specified. QOF is a system intended to improve the quality of general practice and reward good practice.

Effective needs assessment, care and treatment

Clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Templates on the practice computer system linked with guidance to ensure care was provided in accordance with current evidence-based practice. Any new or revised guidance was discussed at regular clinical meetings, and all clinical staff received information about any new or updated guidance.

- 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 may be vulnerable received an assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients who were living with moderate or severe frailty.
- The practice held weekly multidisciplinary team (MDT) meetings with community-based health teams (for example, district nurses) and an allocated social worker to discuss those patients with complex needs. This ensured that all members of the MDT were involved in delivering the best possible holistic care to patients to help them stay safe and well in their own home. Data demonstrated that the practice had lower rates of attendance at the Accident & Emergency department, and lower rates of emergency admissions.
- The practice offered flu vaccinations and monitored uptake. These would be given to patients in their own home if they had difficulties attending the practice.

People with long-term conditions:

- Outcomes achieved for long-term conditions from the most recently published QOF data (2017-18) was 100%.
- Patients with long-term conditions received an annual review to check their needs were being met. There was also usually an interim review to monitor their condition and to review, for example, blood pressure. For patients with the most complex needs, the practice team worked with health and social care professionals to deliver a coordinated package of care.
- The integration of the community matron role within the practice nursing team provided greater continuity of care for patients, and allowed the practice to respond more quickly and appropriately when any issues arose. The practice nurses had a dedicated session each week for community-based work including housebound patient reviews, care planning, and hospital discharges.
- The practice had established effective working relationships with specialist nurses, for example, the community heart failure nurse.
- Care plans were completed with patients and shared with the out-of-hours' service.
- Liaison took place with the local specialist diabetes nurse if any complex issues were identified. The nurse practitioner provided insulin initiation for patients with diabetes.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were significantly above the target percentage of 90%, and all of the indicators we reviewed were above the World Health Organisation (WHO) target of 95%. The practice had arrangements for following up failed attendance for immunisation appointments.
- The practice liaised regularly with health visitors, midwives and school nurses to deliver effective care to families.
- The lead child safeguarding GP attended monthly safeguarding meetings with the health visitor, school nurse and midwife. Alerts were used on the practice computer system to identify any children or families with a potential safeguarding risk.
- The practice adhered to national guidance on determining a younger person's capacity to consent when consulting with them (for example, contraceptive advice).

Good

Are services effective?

- Information was available on chlamydia screening and opportunistic screening was offered. There was a locally based sexual health clinic available.

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

- The daily 'pool' system allowed appropriate patients to access an appointment each weekday. Practice patients were low users of the out-of-hours' service and the Accident and Emergency department.
- The practice's uptake for cervical screening was 84.9%, which was above local and national average and exceeded the 80% coverage target for the national screening programme. The practice had systems in place to check uptake and to recall non-responders.
- The practice's uptake for breast and bowel cancer screening was above local averages and national averages. Both screening rates were over 10% higher than the national figure.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way and six-weekly palliative care meetings were held with the Macmillan nurse. The practice shared appropriate information with the out of hours provider to ensure the patient received the right care promptly, in line with their preferences.
- The practice held a register of patients with a learning disability and offered annual health checks to them. The practice was able to demonstrate that 18 patients (72% of those patients on their learning disability register) had received an annual review of their health needs between April 2017-March 2018. The remaining seven patients had declined to have a review.
- Staff had received training and were aware of what to do, and who to contact, regarding adult safeguarding concerns. They were able to recognise signs of abuse, and staff were aware of the lead GP. The practice was able to provide examples of how they had acted to protect vulnerable adults and achieved positive outcomes for the patient.

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

- The practice assessed and monitored the physical health of people with poor mental health by providing access to health checks, interventions to promote physical activity, and access to 'stop smoking' services.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. A memory clinic was held on site each month. Patients and their carers could access a local programme to support those recently diagnosed with the early stages of dementia.
- A named community psychiatric nurse attended multi-disciplinary meetings with the practice team on a monthly basis. This provided an opportunity to share information and to review any patients with mental health concerns who required additional support.
- The practice had met with a consultant psychiatrist to foster better links and communication with the community mental health team.
- Results from the 2018 national GP patient survey showed 91% of patients felt the healthcare professional recognised or understood any mental health needs during their last appointment (CCG average 91%; national average 87%).
- The practice reviewed suicides as a significant event. This enabled them to consider if any learning could be applied to prevent future occurrences, and raised awareness of high-risk suicides in some patient groups.

Monitoring care and treatment

The practice provided evidence of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- QOF results for 2017-18 showed an overall achievement of 99.5% compared to the CCG average of 98.9%, and a national average of 96%. The public health domain for smoking had been the only area where the practice had performed at less than 100%, with an achievement of 95.3% (CCG average 99.2%; national average 96.9%).
- Exception reporting rates for 2016-17 were in line with averages. We observed that 2017-18 data showed an increase in clinical exception reporting for some conditions, but when this was discussed with the practice, it appeared to be the result of incorrect coding.
- The practice was involved in quality improvement activity. For example, we saw some evidence of a regular clinical audit programme. We saw that two cycle audits had been completed which demonstrated improved outcomes for patients.
- The practice had participated in research projects.

Effective staffing

Good

Are services effective?

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.
- As a training practice there was an emphasis on ongoing learning. A GP registrar told us they received bespoke training focusing on their personal development. This was supported by regular debriefs and clinical meetings to discuss any complex issues.
- 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. The practice identified training and the frequency for updates for different staff groups. Records of skills and qualifications were maintained.
- The practice had an ethos of learning and continual development. Staff were encouraged and given opportunities to develop. For example, a member of the reception team had trained to perform phlebotomy and was undertaking further training to enhance their role.
- The practice provided staff with ongoing support. This included an induction process, appraisals, access to clinical advice, and support for revalidation. We saw evidence of a comprehensive induction programme which included the assessment of key competencies within the initial three-month probationary period.
- There was a procedure in place for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- 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 deciding care delivery for patients. They shared information with, and liaised, with community and social services for housebound patients, and with health visitors and community services for children and their families.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were admitted (and subsequently 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 account of the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff helped patients to live healthier lives.

- The practice identified patients who may 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.
- 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, advice on stopping smoking and tackling obesity. Patients could access the Live Life Better Derbyshire scheme for ongoing support to live healthier lifestyles. GPs could refer patients to 'exercise by prescription' programmes.

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 providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was overwhelmingly positive about the way staff treat people.
- Staff understood patients' personal, cultural and social needs.
- The practice gave patients timely support and information.
- Staff participated in fundraising events to support charities. For example, two GPs had run a half marathon earlier in 2018 to raise funds for a local centre providing care for the homeless, vulnerable and socially excluded.

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). This was highlighted on the home screen of the practice website, which encouraged patients to let the team know of any specific needs so this could be highlighted on their records.

- Staff communicated with people in a way that they could understand, for example, communication aids (for example, a hearing loop) and easy read materials were available.
- 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 latest results from the national GP patient survey showed that patients felt that they were involved in decisions about their care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect.

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. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. The practice was able to demonstrate a proactive approach in engaging with community schemes which benefited all local residents.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal 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 have complex needs.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The co-location with community health providers in the same premises provided easy access to services including physiotherapy and podiatry.

Older people:

- The practice undertook home visits to patients unable to attend the surgery for acute medical problems as well as for chronic disease management. They also offered flu jabs to housebound patients.
- The practice followed up on older patients who had been admitted to hospital or had been flagged as having had contact with the out of hours' or ambulance services. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice provided care for most residents within a local residential home and a nursing home as part of an enhanced service. A clinical session was held at each site every fortnight, and the use of a laptop enabled remote access to patients' records to ensure the delivery of safe and effective care. Staff at the care home told us they received a good service from the practice.

People with long-term conditions:

- There was an emphasis on patient empowerment to understand and self-manage their own condition. For example, patients were provided with written information on their test results for diabetes to enable them to monitor how effectively their condition was being controlled.
- The practice held regular meetings with members of the wider local community health and social care teams to discuss and manage the needs of patients with complex medical issues.
- The practice had participated in a CCG funded scheme for the detection of atrial fibrillation (an irregular heartbeat) which could be assessed using a device linked to a mobile phone application. This was intended to reduce the incidence of strokes.
- The practice offered home visits to meet the needs of this group when required.

Families, children and young people:

- 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.
- The practice provided responsive care for children and younger people, ensuring all children could be seen that day. The practice could offer appointments outside of school hours to accommodate children at a convenient time.
- A midwife and health visitor provided regular clinics on site.
- The practice carried out six-week post-natal checks and this was used as an opportunity to promote the uptake of childhood vaccinations.
- The practice provided family planning services including coil and implant fittings.
- Annual 'Aspire Days' were held in which a GP attended a local primary school to discuss and promote health.
- The practice had accommodated sixth-form work experience students with an interest in applying to medical school. This was managed reciprocally with a Chesterfield practice to facilitate greater confidentiality.

Working age people (including those recently retired and students)

Good

Are services responsive to people's needs?

- The practice offered pre-bookable GP appointments in extended hours on Saturday mornings each week.
- Early morning appointments were available with the healthcare assistant, for example, to take bloods.
- The practice participated in a local extended access scheme which was launched at the end of September 2018. This offered access until 8pm Monday to Friday, and for three hours a day on a Saturday and Sunday.
- The practice offered telephone appointments when appropriate.
- Online services were available including appointment bookings, repeat prescription requests (including the electronic prescription service, enabling patients to collect their medicines directly from their preferred pharmacy), and patients could request access to coded medical records. Online access uptake was above the NHS targets for 20% of patients to sign up for online services.

People whose circumstances make them vulnerable:

- Patients and their families were signposted to local services to help support them with alcohol or substance abuse.
- The Citizens Advice Bureau attended the practice each week to provide information and advice on financial, legal and other personal matters of concern.
- The practice had a range of easy read information for patients with a learning disability.

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

- The practice provided patients with details on self-referral to local counselling services and other services to promote good mental health.
- The practice worked with the local mental health crisis team, community psychiatric nurses, and social care professionals to meet the needs of their patients.
- Longer appointments were available for patients with mental health problems so they did not feel rushed. Telephone consultations were also available should these be required.

Timely access to care and treatment

Patients were mostly able to access care and treatment from the practice within a prompt timescale to meet their needs.

- The practice offered online booking for appointments and the ordering of repeat prescription.
- Patients could access evening and weekend appointments via extended access operated at two local GP locations. These could be booked by reception staff and were available for pre-bookable appointments with a GP or nurse.
- Longer pre-bookable consultation times at 15 minutes in the morning, and 12½ minutes in the afternoon were implemented in recognition of the complex needs of the age profile of their registered patients.

Outcomes from the most recent GP patient survey, published in August 2018, showed that patient satisfaction in relation to access to the service was below average. The practice had taken action to address this including:

- changes to the telephone system by introducing a 'tree' system to let patients know their position in the queue.
- having a 'pool' appointment system from 10am each weekday to ensure any patient with urgent needs, and those who felt they needed to be seen that day, would be seen by a GP or the nurse practitioner.
- advanced bookings up to four weeks ahead, with a staggered release of new appointments each day.
- two additional GP consulting sessions increasing capacity for more appointments.

The practice understood there was further work to be done to inform patients about how access could work to their benefit, and they had plans to engage their PPG with some of this work.

On the day of our inspection, we saw that access was working well, and the feedback received in patient comment cards indicated that patients were happy with the system operated.

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 was mostly in line with recognised guidance, although some updates were identified which the practice reviewed after our

Good

Are services responsive to people's needs?

inspection. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted on complaints to improve the quality of care.

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

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- GP partners and managers were knowledgeable about issues and priorities relating to the quality and future of services. Management team meetings were held weekly.
- The partners and practice manager were visible and approachable. They worked closely with staff and others to ensure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including succession planning arrangements for the practice.
- Clinicians had identified lead areas of responsibility, for example, safeguarding and prescribing.

Vision and strategy

- The practice's mission statement was "working together for better health".
- There were clear aims and objectives for the service. These reflected the provision of high quality care; working in partnership; and being a learning organisation focused on continual improvement.
- The practice planned its services to meet the needs of the practice population and was in line with health and social priorities across the region.

Culture

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

- The practice focused on the needs of patients.
- Staff stated they felt respected, supported and valued. They told us that they enjoyed their work in the practice, and that there were good relationships between all members of the team.
- 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 needed. This included appraisal and career development conversations. All staff had received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were given protected time to support their professional development.
- There was an emphasis on the safety and well-being of all staff. For example, longer consultation times helped reduce pressures on clinicians.
- The practice promoted equality and diversity and had a policy to support this.
- There were positive relationships between staff and individuals/teams who worked with the practice.
- An 'away day' event was held on an annual basis to promote team building.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were established, understood and mostly effective.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety. These were operating as intended, with the exception of adequate assurances on the cold chain procedure.
- There was a timetable of regular practice meetings, including clinical meetings where topics including new and revised guidance, prescribing data, clinical incidents and complaints, and emerging risk could be discussed.
- A GP attended the local CCG-led clinical governance leads meeting, and provided feedback to the practice team on relevant issues.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. However, we found that the oversight of monitoring procedures for vaccine refrigerators required strengthening.

Good

Are services well-led?

- The practice monitored, reviewed and benchmarked activity. This gave a clear, accurate and current picture of performance and enabled corrective actions to be taken if required.
- Practice leaders had oversight of safety alerts, incidents, and complaints.
- The practice had a business continuity plan in place for major incidents.

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.
- The practice used information to assess performance and to take corrective actions if these were indicated. The practice engaged with their CCG to discuss performance.
- 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. A patient participation group was in place.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for continuous improvement and innovation.

- The practice was an established training practice supporting GP registrar and medical and nursing student placements. The practice had received an Excellence in Education award in 2016 in recognition of the feedback received from training placements. The focus on learning was maintained by ongoing clinical discussions, for example in daily meetings to discuss any new patient referrals to secondary care services.
- The practice was able to demonstrate how they were integral to their local community by a range of initiatives they had implemented or participated within. For example, a 'cardio club' which promoted healthy lifestyles, and an annual 'Aspire Day' engaging with local primary schools.
- A programme of clinical audit ensured improvements for patients. Audit topics were selected in relation to a range of influences including prescribing guidance, MHRA alerts, and significant events.

Please refer to the Evidence Tables for further information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered provider had not ensured safe systems were in place to monitor vaccine refrigerator temperatures. This meant that the practice could not always provide evidence that vaccines were being stored within the temperature ranges specified by national guidelines.