

Avenue House and Hasland Partnership

Quality Report

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Avenue House & Hasland Partnership on 22 April 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. Learning was applied from events to enhance the delivery of safe care to patients.
- Risks to patients were assessed and well managed in conjunction with the wider multi-disciplinary team.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- The practice team had the skills, knowledge and experience to deliver high quality care and effective treatment, and were supported to develop their roles via a robust appraisal process. A number of clinical

staff had undertaken additional training to enhance their skills and had developed areas of special interest to support them in taking lead roles within the practice.

- Feedback from patients was consistently positive about the care they had received. Patients said they were treated with compassion, dignity and respect and they were actively involved in decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients told us they were able to access care and treatment when they needed to, and had a positive experience when making an appointment. Access to a preferred GP was significantly above local and national averages, and the practice always tried to offer continuity by the same GP consulting with the patient for routine, urgent and telephone appointments or home visits.
- The practice had good facilities and was well-equipped to treat patients and meet their needs. The premises were clean and tidy and the grounds were well maintained.

Summary of findings

- There was a clear leadership structure and staff told us that they felt supported by management. The leadership and governance arrangements were robust and focused upon continuous improvement.
- The practice analysed and responded to feedback received from patients. Comments were used to adapt services where possible to best meet patients' needs.
- There was an active patient participation group which influenced practice developments. For example, a clinician notice board had been prominently displayed at the reception desk to inform patients which GPs were on duty each day.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers and their Clinical Commissioning Group (CCG). For example, the practice was dedicated to supporting pilot projects within primary care and was supported by the CCG to trial new developments. For example, one GP had initiated a local project to help reduce the waste of prescribed medicines.
- The practice provided personalised care to those patients at end-of-life. Practice data showed that 92%

of patients had died within their preferred place as a consequence of the planning and support offered by the practice working in conjunction with the wider health and social care teams.

- The practice mission statement of 'helping the person by knowing the person' was reflected in the continuity of care provided with the same GP. This included the named GP doing their own home visits wherever possible; urgent on the day appointments being allocated to the named GP wherever possible; and telephone consultations being undertaken by the named GP. National patient survey data indicated patients rated the practice highly on continuity of care.

The areas where the provider should make improvement are:

- The practice should ensure that all actions in respect of infection control audits are documented.
- Ensure that actions from significant event reviews are documented upon completion.

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?

- There was an effective system in place for reporting and recording significant events, and lessons were shared to make sure actions were taken to improve safety in the practice. Staff told us there was an open culture which encouraged all incidents to be reported.
- The practice had defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- The practice had robust recruitment procedures to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- Potential risks to patients and the public were assessed and well-managed including procedures for infection control and site-related health and safety matters.
- Risks to vulnerable patients with complex needs were regularly monitored by multi-disciplinary team meetings to provide holistic care and ensure patients' needs were met.
- The procedures for managing medicines safely (including vaccines and emergency medicines) were appropriate with good systems to store, monitor and control stock levels.
- The practice had effective systems in place to respond to medical emergencies.
- The practice ensured staffing levels were sufficient at all times to effectively meet their patients' needs.

Good



Are services effective?

- The practice team delivered care in line with current evidence-based guidance, and we saw evidence that this was being used to influence and promote good outcomes for patients.
- Data showed patient outcomes were generally above average for the locality. The practice had achieved an overall figure of 100% for the Quality and Outcomes Framework 2014-15. This was 1.9% above the CCG average and 6.5% above the national average. The exception reporting rate at 12% was in line with averages (local 11%; national 9.2%).
- Clinical audits demonstrated quality improvement, and we saw examples of full cycle audits that had led to improvements in patient care and treatment.

Good



Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment. Some GPs had specific areas of interest including heart disease and substance misuse, and acted as a resource for their colleagues.
- All staff had received role specific inductions, and had received a performance review in the last 12 months which included an analysis of their training needs.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs, in order to deliver care more effectively. This was supported by monthly meetings attended by a wide range of health and care professional staff.
- The practice had a good skill mix and kept this under constant review. An in-house pharmacist and prescribing technician from the CCG visited the practice weekly and provided advice and support on a range of issues relating to medicines.
- Emphasis was placed on supporting people to live healthier lives by offering health promotion advice, and encouraging regular health reviews and screening checks.

Are services caring?

- Staff were motivated and inspired to offer personalised care that promoted patient-centred care. We observed Staff treated patients with kindness and respect, and maintained confidentiality throughout our inspection.
- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated they were treated with compassion, dignity and respect and felt involved in decisions about their care and treatment. This was reflected by the national GP survey (January 2016) which showed that patients rated the practice marginally above local averages, and higher than national averages, in respect of care. For example, 94% of patients said the last GP they spoke to was good at treating them with care and concern which was the same as the CCG average of 91%, and above the national average of 85%.
- A member of the administration team had been assigned as the practice carer's lead, and had established links with the local Carers' Association
- One GP worked voluntarily one day each week to provide support to a local centre for homeless people.
- Feedback from community based health care staff and care home staff was consistently positive with regards to the high levels of care provided by the practice team.

Good



Summary of findings

- The practice provided personalised care to those patients at end-of-life. Practice data showed that 92% of patients had died within their preferred place as a consequence of the planning and support offered by the practice working in conjunction with the wider health and social care teams.

Are services responsive to people's needs?

Are services responsive to people's needs?

Good



- Routine GP appointments were usually available within a week, and urgent appointments were available on the day. Extended hours GP appointments were available at Avenue House one evening each week, and extended hours early morning appointments were available on three days each week between 7am and 8am. Hasland Surgery offered extended hours appointments on one evening each week. Patients could book a routine appointment up to two months in advance.
- Comment cards and patients we spoke to during the inspection were mostly positive about their experience in obtaining a routine appointment. This was reinforced by the national GP survey in January 2016 which found that 97% of patients were able to get an appointment to see or speak to someone the last time they tried (this was significantly above the CCG average of 88% and the national average of 85%).
- Continuity of care was provided. The national GP survey demonstrated that 83% of patients with a preferred GP usually got to see or speak to that GP compared to a CCG average of 61% and a national average of 59%.
- The practice hosted some services on site which made it easier for their patients to access them. This included a weekly Citizens Advice Bureau session to assist with benefits advice; and a visiting well-being worker to promote healthy lifestyles.
- The practice proactively sought patient feedback and implemented improvements and made changes to the way it delivered services as a consequence.
- The premises were well-maintained and clean, and were well-equipped to treat patients and meet their needs. The practice accommodated the needs of patients with disabilities, including access via automatic doors and the availability of a hearing loop.
- The practice provided care for a large number of residents in seven local care and residential homes for older people and people with a learning disability. We spoke to staff in four of

Summary of findings

these homes who informed us that the practice was very responsive to their patients' needs. Urgent visits were done on the day when required and planned 'ward round' visits ensured patients were kept under regular review.

- Information about how to complain was available and the practice responded quickly when issues were raised. Complaints were investigated and acted upon to improve services whenever this was applicable.

Are services well-led?

Good



- The partners aimed to deliver high quality care and promote good outcomes for patients. A clear mission statement promoted the practice ethos of helping the patient by getting to know them. This focus on personalised care was reflected in all aspects of the practice's work.
- There was an overarching governance framework which supported the delivery of the values and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The partners worked collaboratively with the CCG and with other GP practices in their locality. For example, the practice had just undertaken a pilot scheme to review products supplied to patients with incontinence. They were in discussion with their CCG to develop an improved and cost effective service based on the outcomes of the pilot, with aspirations to roll out the scheme locally.
- The partners reviewed comparative data and ensured actions were implemented to address any areas of outlying performance.
- There was a clear leadership structure and staff felt supported by management. The practice held regular staff meetings
- The practice had developed a range of policies and procedures to govern activity
- Patients were actively canvassed for their views on the service. All feedback was reviewed and where possible was used to improve patient experience in the future.
- The PPG made a valuable contribution to practice developments and were actively involved in practice work streams.
- The practice used innovative methods to improve patient outcomes, working with other local providers and their Clinical Commissioning Group (CCG). The practice had initiated several developments and strived to continually improve.

Summary of findings

- High standards were promoted and owned by all practice staff and teams worked together across all roles. There were robust systems in place to aid communication between all groups of staff with regular formal and informal meetings. There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff told us they highly valued the level of support they received from the partners and practice management and highlighted the strong team working.

Summary of findings

The six population groups and what we found

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

Older people

Good



- The practice had higher numbers of older people registered with them compared to the national average (for example 21.1% of patients were over 65, compared against a national average of 17.1%), although this was in line with the local average. Data indicated that there was an increase in registered older patients, particularly those aged 85 and above, and the practice ensured that their services were tailored to meet their needs.
- Each patient was allocated a named and accountable GP responsible for the co-ordination of their care.
- The practice held monthly multi-disciplinary meetings to discuss the most vulnerable patients and those at risk of hospital admission. This facilitated planning and the co-ordination of care to best meet their patients' needs.
- The practice used bespoke care plans to provide clear information on individual needs, including patient preferences. This information was shared with out of hours' services and other agencies to provide co-ordinated care for patients, and helped to reduce the number of unnecessary hospital admissions.
- Longer appointment times were available and home visits were available for those unable to attend surgery.
- The practice provided care to patients across five local residential and nursing homes for older people. The GP or nurse practitioner provided visits to these homes. We spoke to a representative of one of these homes who told us that the nurse practitioner visited every two weeks and undertook a ward round, and that the practice responded to any urgent patient needs on the same day. They described the relationship with the practice as extremely positive.
- 74% of patients aged over 75 had received an annual health check in the last 12 months.
- Flu vaccination rates for people aged 65 and over at 79.4% were slightly higher than the CCG average of 75.9%, and above the national average of 72.8%.

People with long term conditions

Good



- QOF achievements for clinical indicators were higher than CCG and national averages. For example, the practice achieved 100% for diabetes related indicators, which was above the local

Summary of findings

and national averages of 96.7% and 89.2% respectively. Exception reporting rates relating to some individual indicators for diabetes were higher than average, although we saw these were appropriate and the practice were taking measures to engage patients to attend the practice for a review.

- The practice undertook annual reviews for patients on their long-term conditions registers. This occurred in the patient's birthday month and included a review of the patient's prescribed medicines to check if any changes were required.
- GPs held lead roles in managing long-term conditions, including a GP who specialised in heart problems. This GP also provided input at a local angina clinic which was attended by patients from across the locality.
- There were nurse-led clinics available including support for patients with diabetes, asthma and chronic obstructive airways disease.
- The practice worked closely with specialist nurses including the heart failure and diabetes specialist nurses.
- The practice provided INR monitoring at the practice and within patient's homes. INR testing measures the length of time taken for the blood to clot to ensure that patients taking particular medicines were kept safe.
- The practice was working with their CCG to enhance care for housebound patients with a long-term condition. This involved working to a new specification, retraining and re-allocation of finances with an overall aim to improve care for this group of patients.

Families, children and young people

- Meetings were held every six weeks between the GPs, practice nurses, and health visitors and midwives to discuss any vulnerable children. We spoke with the health visitor who informed us that the practice responded promptly to any issues raised, and were always responsive to younger people's needs.
- Urgent appointments were available each day for unwell children, and telephone advice was offered to parents. Appointments were provided outside of standard school hours.
- The practice provided a joint new baby development and vaccination clinic. Nurses worked in pairs to minimise the potential stress for the baby and the parents. The nurses had produced an information leaflet for parents to advise them about the best way to hold their child during the procedure. This had been developed in response to a complaint that parents had felt that staff had not assisted them to support and hold their infant during the vaccination procedure.

Good



Summary of findings

- Immunisation rates for all standard childhood immunisations were comparable to local averages. For example, vaccination rates for children aged five and under ranged from 92.2% to 98.3%, compared against a CCG average ranging from 95.2% to 99.1%.
- The practice had a prominently placed display targeted at 14-19 year olds to encourage them to attend for an appointment with any health related concerns. This welcomed consultations either with parents or individually.
- The practice provided baby changing facilities, and there was a small play area for younger children. The practice welcomed mothers who wished to breastfeed on site, and provided a private room for them when possible.
- Chlamydia testing kits were readily available to encourage uptake from younger people.

Working age people (including those recently retired and students)

- The practice offered on-line booking for appointments and requests for repeat prescriptions. The practice provided electronic prescribing so that patients on repeat medicines could collect them directly from their preferred pharmacy. The practice had encouraged 25% of their patients to register on-line which was higher than other local practices.
- The practice provided telephone access each morning to the patient's preferred GP, and urgent telephone advice was available in the afternoon.
- Extended hours' GP consultations were available at both locations. Both sites offered evening appointments once a week, and one site provided early morning appointment on three days each week.
- The practice offered health checks for new patients and NHS health checks for patients aged 40-74.
- The practice promoted health screening programmes to keep patients safe. For example, 64% of patients aged 60-69 had been screened for bowel cancer against a national average of 55.4%. This had been achieved by the practice promoting this by a targeted letter being sent to patients.
- Health Trainer sessions were held on site each week for advice regarding diet, smoking, alcohol and exercise.

Good



Summary of findings

People whose circumstances may make them vulnerable

Good



- The practice had undertaken an annual health review for 57% of patients with a learning disability in the last 12 months. All 52 patients that received a review had a care plan in place.
- The practice provided care to two local care homes for patients with a learning disability. One home cared for residents aged 19-36, mostly with autism and challenging behaviour, whilst the other cared for patients above 40. We spoke to a manager at the home for the younger people who spoke of a highly responsive service with two-weekly visits provided by the nurse practitioner, and gave examples where patients had achieved good outcomes.
- The practice worked in line with recognised standards of high quality end of life care Palliative care meetings were held every six weeks between the practice clinicians and district nurses and the Macmillan nurse. An analysis of patient deaths was undertaken for patients with cancer to ensure any learning points were considered, and ensure that best practice was shared with the whole team. Practice data showed that 92% of patients had died within their preferred place as a consequence of the planning and support offered by the practice working in conjunction with the wider health and social care teams.
- The practice adopted a co-ordinated approach to care by the use of locally developed care plans, which ensured key information was shared with other providers such as the out of hours service. The practice had been instrumental in the development of these care plans which were used extensively by other local practices.
- The practice supported the local homeless centre as the first point of call for their patients to register.
- The practice provided a joint substance misuse service with a support worker from a local provider.
- The practice had undertaken a best interest assessment on their patients with pronounced learning disabilities to consider if they should receive a cervical smear test.
- The practice was a recognised 'safe haven' for vulnerable people including those with a learning disability. This Derbyshire partnership scheme aimed to protect people from potential bullying or abuse. It helped them feel safe and confident when out in the community by having access to a place where they could be supported if required.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good



- The practice achieved 100% for mental health related indicators in QOF, which was 1.9% above the CCG and 7.2% above the national averages, with exception reporting rates generally in line with averages.
- 95.5% of patients with a diagnosed mental health problem had a care plan documented in the preceding 12 month period which was marginally above the CCG average of 93.3%, and above the national average of 88.3%. However, exception reporting at 21% was 3.6% higher than the CCG, and 8.4% higher than the national averages.
- 73.8% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was approximately 10% lower than local and national averages, although the exception reporting rate was marginally lower.
- 50% of patients on the practice's mental health register had received an annual health check during 2014-15, and 62% of patients had a care plan in place.
- The practice had completed 'Dementia Friends' training for staff to improve their awareness of dementia and the support available to patients and their carers, and planned to qualify as a 'dementia-friendly practice'. There was also a designated 'Dementia Champion' in the practice team, and a member of the PPG was a dementia advocate who trained staff in other practices.
- The practice had audited missed appointments for patients with dementia . Whilst the rate was low at 1.2%, the practice had agreed to develop a dementia-friendly letter for these patients with information on appropriate support groups and services
- A community psychiatrist nurse worked with the practice, and attended monthly multi-disciplinary meetings, to support patients experiencing poor mental health.
- The practice had a nominated carers champion and had developed links with the local Carers Association.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in January 2016. The results showed the practice was performing in line with, or above local and national averages. A total of 279 survey forms were distributed and 128 were returned, which was a 46% completion rate of those invited to participate.

- 85% of patients found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 97% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 88% and a national average of 85%.
- 83% of patients with a preferred GP usually got to see or speak to that GP compared to a CCG average of 61% and a national average of 59%.
- 86% of patients described their experience of making an appointment as good compared to a CCG average of 77% and a national average of 73%.
- 94% of patients would recommend this surgery to someone new to the area compared to a CCG average of 84% and a national average of 78%.
- 86% of patients found the receptionists at this surgery helpful compared to a CCG average of 89% and a national average of 87%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 15 patient comment cards and these were all extremely positive regarding patient experience at the practice. Patients commented that they were treated with care and respect, and were given sufficient time to discuss their health problems during consultations. Two patients stated they sometimes experienced difficulties in obtaining a routine appointment, but balanced this with positive comments regarding all other aspects of the service received.

We spoke with seven patients during the inspection. All of the patients we spoke with said that they were cared for with dignity and respect by the practice staff; that they were provided with sufficient consultation time; that scheduled appointments usually ran on time; and that the practice was always clean and tidy. Patients told us that they were provided with explanations on treatment and medicines during consultations. Patients were mostly satisfied with the appointment system and said they were offered a choice of which GP they could see.

Avenue House and Hasland Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a nurse specialist advisor, and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service

Background to Avenue House and Hasland Partnership

Avenue House & Hasland Partnership provides care to approximately 14,244 patients from two locations within the Chesterfield area of North East Derbyshire:

- Avenue House Surgery.109, Saltergate. Chesterfield. Derbyshire. S40 1LE
- Hasland Surgery.82, St Philips Drive. Hasland, Derbyshire. S41 0RG

These two surgeries merged as one practice in April 2014. Hasland Surgery was inspected by the CQC under our previous inspection regime in June 2013, and found to be compliant with the standards assessed. Our inspection on 22 April was based at the Avenue House site.

The surgery provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England, and services commissioned by North Derbyshire Clinical Commissioning Group (CCG). Avenue

House operates from modernised former residential premises which are maintained to a high standard. Hasland Surgery is a purpose built property which was extended in 2009.

The practice is run by a partnership of six GPs (three males and three females). The partners employ three salaried GPs (two males and one female). This equates to just over eight full time GPs working within the practice at the time of the inspection. The practice was using winter pressure funding provided by the CCG for an additional part-time salaried GP to increase capacity to see patients during the winter periods, and were considering if this would be made permanent.

The partnership is an established training and teaching practice and accommodates GP registrars (a qualified doctor who is completing training to become a GP); and medical students.

The practice employs two nurse practitioners and four practice nurses. The nursing team is complemented by four health care assistants and two phlebotomists. The clinical team is supported by a practice manager, an assistant practice manager, and a team of 22 administrative and reception staff.

The registered practice population are predominantly of white British background. The practice is ranked highly within the CCG in terms of the deprivation status of their registered patients, although this figure is in line with national averages. The practice age profile has higher numbers of patients aged over 45 compared against the national average, and is showing an upward trend in terms

Detailed findings

of the percentage of registered older patients (65 years plus). The practice has higher numbers of patients with a learning disability, and a higher than average prevalence of mental health issues.

The practice opens from 8am until 6.30pm Monday to Friday. Scheduled GP morning appointments times are available from 8.30am to 11.00am approximately, and afternoon surgeries run from 3.30pm to 5.30pm, apart from one Wednesday afternoon each month when the practice closes for staff training. Extended hours GP appointments are available at Avenue House every Monday evening from 6.30pm to 8.30pm, and extended hours early morning appointments are available on three days each week between 7am and 8am. Hasland Surgery offers extended hours appointments every Monday evening between 6.30pm and 7.30pm.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed patients are directed to Derbyshire Health United (DHU) via the 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the Care Quality Commission (CQC) at that time

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 including NHS England and NHS North Derbyshire CCG to share what they knew.

We carried out an announced inspection at the Avenue House site on 22 April 2016 and during our inspection:

- We spoke with staff including GPs, the practice manager, the assistant practice manager, practice nurses and members of the reception and administrative team. In addition, we spoke with representatives from four local care homes, the district nursing team, the community matron and the CCG pharmacist regarding their experience of working with the practice team. We also spoke with seven patients who used the service, and two members of the practice patient participation group.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 15 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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

Detailed findings

- 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)

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- An incident report template was available on the computer to report any incidents, and staff understood the process to follow. Staff told us they would inform the practice manager of any incidents that occurred, and that they received feedback on any learning points. They said the practice operated a 'no blame' culture and encouraged staff to report all incidents.
- The practice carried out an analysis of the significant events and reviewed these at practice meetings where any learning points were identified.
- People received support, truthful information, an apology when there had been an unexpected safety incident, and were told about any actions taken to prevent the same thing happening again.

We reviewed incident forms for the 21 significant events recorded by the practice team over the preceding 12 month period. This incorporated a range of incident types and included positive events to celebrate success. Learning points were identified to improve safety in the practice and actions were documented. For example, a patient attended for an appointment intended for another patient with a same name. This was identified by the staff member prior to any intervention, and the practice took action to ensure that patients were checked by means of three separate identifiers to confirm patient identities. The practice did not always document when agreed actions had been completed but stated that this would be implemented in the future.

The practice had a process to review and cascade patient safety alerts, and medicines alerts received via the Medicines Health and Regulatory Authority (MHRA). When this raised concerns about specific medicines, searches were undertaken to check individual patients and ensure effective action were taken to ensure they were safe. For example, prescribing an alternative medicine if a concern had been raised about the safety of a particular medicine.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to staff. The policies outlined who to contact for guidance if staff had concerns about an individual. There were lead GPs for safeguarding both children and adults, who had received training at the appropriate level (level 3) in support of these roles. Child safeguarding meetings were held with the health visitor and midwife approximately every six weeks, which were documented. Practice staff demonstrated they understood their responsibilities in identifying and reporting any safeguarding concerns, and had received training relevant to their role. We viewed a significant event which demonstrated that staff responded to concerns quickly and effectively to ensure that the patient was safe.
- A notice in the reception and the consulting rooms advised patients a chaperone was available for intimate examinations, if required. Nursing staff would act as a chaperone, but members of the reception and administration team were trained for this role, and could also provide this service. These staff had received a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had organised specialist chaperone training on site and invited some staff from other local practices to attend this well-received training event.
- We observed that the practice was tidy and maintained to high standards of cleanliness and hygiene. A nurse practitioner was the lead for infection control who had undertaken specific training to support this aspect of their role. Infection control policies were in place and staff had received up to date training. Annual infection control audits were undertaken, most recently in August 2015. There was no documented evidence available to demonstrate that actions had been completed, although we were observed that improvements had been made as a result of the audit. Staff stated they would ensure that all actions were fully documented in future. The practice contracted cleaning services to an

Are services safe?

external provider and had developed specific cleaning schedules that were regularly monitored. The practice manager met with the cleaning contractor manager on a monthly basis and systems were in place to quickly rectify any issues that arose.

- Appropriate staff had received hepatitis B vaccinations. As this service had previously been withdrawn by their provider, the practice was introducing the vaccination programme in house for their own staff.
- The arrangements for managing medicines in the practice, including emergency medicines and vaccinations, kept patients safe. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Monthly medicines stock checks including expiry dates were undertaken and we saw documented evidence of this. Signed and up-to-date Patient Group Directions were in place to allow nurses to administer medicines in line with legislation, and healthcare assistants administered medicines against a patient specific prescription or direction from a prescriber.
- We reviewed four staff files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the DBS checks.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and there were risk assessments in place to monitor safety of the premises such as the control of substances hazardous to health. Staff had received fire training, and the practice had conducted their own fire risk assessment in March 2016. A robust external fire assessment had previously been undertaken at Avenue House, and more recently at Hasland Surgery (November 2014) when fire systems had been upgraded following the practice merger. Trial evacuations had been carried out and the practice was aware that this was due for a review in the near future. All fire and electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. A formal risk assessment for legionella (legionella is a term for a

particular bacterium which can contaminate water systems in buildings) had been recently completed. The practice was in the process of working through the recommendations of their legionella report at the time of our inspection.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. The practice team worked flexibly to ensure adequate cover was available at all times, including an identified GP to support the registrars working at the practice. Demand for GP appointments was closely monitored and if more capacity was required, and additional GP hours, were organised to address this. The practice rarely used locum GPs but when this happened, they would only use GPs who had a history of working at the practice therefore familiar with systems and the practice team ethos.

Arrangements to deal with emergencies and major incidents

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

- An audible alarm was in place, and there was an instant messaging system on the computers in all the consultation and treatment rooms and patient areas which alerted staff to any emergency. A portable screen was available in case a situation arose in the waiting area.
- All staff had received annual basic life support training, and was last completed in November 2015.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date, and the practice had developed a process to write details on the box of the medicine when a replacement had been ordered to prevent over-ordering stocks.

The practice had a business continuity plan for major incidents such as power failure or building damage. A copy of the plan was kept off site in case access to the premises was not possible. The plan was reviewed regularly with the most recent update in January 2016.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, and local guidance, for example, in relation to prescribing. There was a lead GP for NICE who provided summaries of new or revised guidance for easy reference, and other clinicians were kept up to date when guidance was received or updated.

The practice had undertaken work to develop the templates used for specific conditions to a high specification. This helped to ensure full and accurate information was recorded and consistently coded. We observed examples of templates, including those developed for hypertension (high blood pressure) and end of life care.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2014-15 were 100% of the total number of points available. The practice had an overall exception reporting rate of 12%, compared to a local average of 11% and national average of 9.2%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients had repeatedly failed to attend a review meeting or certain medicines could not be prescribed because of side effects.

QOF data from 2014-15 showed:

- Performance for diabetes related indicators at 100% was above the local and national averages of 96.7% and 89.2% respectively. Some of these indicators displayed above average exception reporting rates but the practice had implemented measures to encourage patient compliance to have their conditions reviewed regularly. For example, the nurse had introduced telephone screening for patients with diabetes.

- Performance for indicators related to asthma at 100% was above the local average of 97.6% and national averages of 97.4%, with exception reporting rates marginally above local and national averages.
- The percentage of patients with rheumatoid arthritis who had received a face to face received in the preceding 12 months at 95.9% was 1.4% above the local average and 4.9% above the national average. Exception reporting at 23.7% was higher than the CCG average of 9.3% and 7.3% nationally. However, we observed that the practice was exempting patients in accordance with national guidance.
- Performance for mental health related indicators was higher than local and national averages at 100% (98.1% and 92.8% respectively). Exception reporting levels for 50% of these indicators were generally above local and national averages.
- Practice supplied data (as yet unpublished and subject to external verification) showed that QOF performance for 2015-16 had been maintained at 100%

There was evidence of quality improvement including clinical audit.

- There had been 14 audits undertaken in the last two years. Four were completed two cycle clinical audits where findings were used by the practice to improve patient care. We reviewed three completed audits where the improvements made were implemented and monitored. For example, the nurse practitioner had completed a full clinical audit cycle in 2016 which demonstrated an improvement in the safety and efficacy of the INR monitoring process (the INR measures the clotting rate for blood to ensure the correct dosage of medicine is being taken). This was achieved by encouraging clinicians to use the recommended computer-assisted dosing tool, and to clearly document the rationale for overriding the recommended dose and review date.
- The practice carried out medicines audits, with the support of the local CCG medicines management team, to ensure prescribing was cost effective and adhered to local guidance. We observed data that showed the prescribing of antibiotics was repeatedly lower than local and national averages.
- We observed that other practice staff including the nurse practitioner and assistant practice manager had led on audits.

Are services effective?

(for example, treatment is effective)

- The practice participated in local benchmarking activities. For example, the practice had reviewed Accident & Emergency (A&E) attendances with a focus on those patients who had multiple attendances. The practice arranged to see these patients to discuss the particular issues about their repeated attendances at A&E and reviewed their prescribed medicines and updated their care plans. We were provided with an example of how the practice had worked with a patient to resolve anxieties about their chest pain, which had resulted in the patient no longer attending A&E. The practice was below the CCG average A&E attendance rates indicating good GP access, care planning and patient education.
- Staff undertook additional qualifications to enhance their skills and provide enhanced care for patients. For example, a nurse practitioner was completing a master's degree in elderly care.
- The practice had introduced a competency framework for practice nurses and health care assistants linked to a pay scale. This helped encourage staff to develop in their roles, and ensured that staff were trained to a high level of expertise and received recognition for this.
- A prescribing CCG pharmacist provided input at the practice for one day each week. This role incorporated reviewing patients on multiple medicines; reviewing any patients where there were compliance concerns with regards taking their prescribed medicines; and ongoing monitoring and reviews of particular medicines. The pharmacist was well integrated with the practice team, and provided benefits in the co-ordination of patient care and valuable support to the GPs.

Effective staffing

- GPs had designated lead clinical areas and acted as a resource for their colleagues.
- The practice had induction programmes for all newly appointed staff, and we saw examples of these which had been signed off by both the employee and practice manager.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. Staff had received an appraisal within the last 12 months. We spoke to members of the team who informed us of how learning opportunities had been discussed during the appraisal and subsequently supported. For example, a member of staff who was involved in the administration for the cervical screening programme went to visit the laboratories to improve their knowledge of how the screening process works.
- Staff received training that included safeguarding, fire safety awareness, and basic life support. Staff had access to and made use of e-learning training modules and in-house training. A training matrix had been developed to collate details on the training status of the whole practice team. The practice had monthly protected learning time in which they either attended an event organised by their CCG, or arranged in-house training for the practice team.
- The practice ensured role-specific training with updates was undertaken for relevant staff. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.

Coordinating patient care and information sharing.

- The information needed to plan and deliver care and treatment was available to clinicians in a timely and accessible way through the practice's electronic patient record system. This included care plans, medical records, and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services, or raising safeguarding concerns.
- The practice team worked collaboratively with other health and social care professionals to assess the range and complexity of patients' needs and plan ongoing care and treatment. Monthly meetings took place with representation from a wide range of professionals including the community psychiatric nurse, physiotherapist, social worker, the community matron, the district nurse, and the care co-ordinator. These meetings were documented with any agreed actions being recorded.
- In addition, six weekly palliative care meetings were held between the practice team, the district nurse and Macmillan nurse to review those patients on the practice's palliative care register. This meeting included a discussion of any new cancer diagnoses, and a review of any patient deaths to consider any learning points.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Where a patient's mental capacity to consent to care or treatment was unclear, the clinician assessed the patient's capacity and, recorded the outcome of the assessment. The practice had undertaken a review of patients with a learning disability who were in the eligible age range for cervical screening but had not had a test. The practice had discussions with patients, care home staff, and relatives to assess each case individually. A best interest decision was taken to record that risk factors had been reviewed, and that the screening was not appropriate. This was documented in each patient's record.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Clinicians were able to articulate how this applied in individual cases, and the actions they would take to adhere to the guidance correctly.
- Written consent forms were completed for specific procedures including vaccinations, coil fittings and minor surgical procedures.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- A health trainer was available each week to provide advice on healthier lifestyles, including diet, alcohol

consumption, and social issues including debt management and isolation. The health trainer was able to signpost patients into ongoing community based support programmes including services to help patients stop smoking.

The practice's uptake for the cervical screening programme was 81.8%, which was in line with the national average of 81.9%, but with much lower exception reporting (1.8% vs 6.3%). There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice encouraged patients to attend national cancer screening programmes, and uptake was in line with local and national averages for breast cancer screening, but bowel cancer screening was higher. For example, 64% of patients aged 60-69 had been screened for bowel cancer within six months of invitation, against a national average of 55.4%. This had been achieved by the practice promoting this by a targeted letter being sent to patients.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93.4% to 97.1% (local average 95.2% to 98.9%) and five year olds from 92.2% to 98.3% (local average 96.5% to 99.1%).

The practice provided health checks for new patients and NHS health checks for patients aged 40-74. A total of 55.4% of patients offered this assessment in the last 12 months had attended the practice to receive this check. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice had completed a full cycle audit to look at the uptake of health checks compared to the numbers invited to attend. Results demonstrated a 20% increase in the checks performed in the last year.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and helpful to patients and treated people with dignity and respect throughout our inspection.

- Disposable curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations and treatments.
- Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.
- If patients wanted to discuss sensitive issues, or appeared distressed, they were offered a private room to discuss their needs.

Patients we spoke with told us they were listened to and were treated with compassion, dignity and respect by clinicians. Results from the national GP patient survey in January 2016 showed the practice was in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% of patients said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 92% of patients said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 94% of patients said the last GP they spoke to was good at treating them with care and concern which was the same as the CCG average of 91%, and above the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern in line with the CCG average of 93% and national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Residential home staff and community health care staff provided us with examples of effective care provided by the practice team. For example, one home provided an

example of how the visiting nurse practitioner had spent time working with a young resident to gain their confidence in attending a cervical smear test, further to a previous poor experience.

The practice ran baby clinics with two nurses in attendance. This was in recognition of the potential distress that both the child and parents can experience, for example, when the child received their vaccinations. The practice had designed a leaflet to send to parents prior to their attendance to explain why the parents needed to hold the child throughout procedures including immunisations. This had been developed in response to concerns that this could be distressing for parents, and an assumption that the nurses could help to restrain the child.

Reception staff reported any significant concerns about patients arriving at the surgery to ensure urgent access to treatment. A recent example included a patient who attended with an unusual presentation of cardiac chest pain. The immediate action taken by the team ensured the patient received the necessary urgent treatment, and rapid transfer to hospital.

The partners and managers cared for their welfare of their employees and there was a low staff turnover. The practice had supported as many staff as possible to attend the funeral of a former staff member to allow them to pay their respects to valued colleague.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in decision making about the care and treatment they received, and feedback on the patient comment cards we received aligned with these views. A caring and patient centred attitude was demonstrated by all staff we spoke with during the inspection.

Results from the national GP patient survey showed results were in line with local and national averages in relation to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 95% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 82%.

Are services caring?

Patient and carer support to cope emotionally with care and treatment

The practice identified patients who may be in need of extra support, including patients in the last 12 months of their lives, and carers.

Notices in the patient waiting room told patients how to access a number of support groups and organisations, and a range of leaflets were available for patients.

There was an alert on the practice's computer system to inform clinicians if a patient was also a carer. The practice had identified 2.1% of the practice list as carers, and identified new carers upon registration. Written information was available to direct carers to the support services available to them. Links had been established with the Derbyshire Carers Association, and the practice had an

identified team member to act as the 'Carers' Champion' to aid the identification and support of carers. The practice planned to run an in-house campaign to promote carers' support as part of the national 'Carers Week' in June 2016.

The practice worked to recognised high quality standards for end of life care and had written care plans in place to ensure that patient wishes were clear, and that they were involved in the planning of their own care. An audit of 50 palliative care patients who had died in the last 12 months demonstrated that 92% had died in their preferred place. The practice team called relatives who had experienced a bereavement to offer condolences, and support, including signposting to appropriate services such as counselling, was available if required. One patient described their GP as 'being part of the family' following a recent bereavement, and told us the GP provided extensive care and support to the patient and family prior to the patient's death.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, A GP had helped to establish a local community based angina clinic which was a three month educational programme to relieve stress and anxiety. The GP had been involved in this service which was available to all local practices. Outcomes demonstrated over a three year period that 14 of 16 patients who were to be referred for bypass surgery managed to avoid surgery by controlling their symptoms.
- The overall achievements from the GP survey placed this practice as having the best ratings in the Chesterfield area, and the second best result across the whole CCG
- The practice upheld their mission statement of 'helping the person by knowing the person' and did their best to offer continuity with the same GP. This included the named GP doing their own home visits wherever possible, rather than these being collated into one visiting list for one GP; urgent on the day appointments being allocated to the named GP wherever possible; and telephone consultations being undertaken by the named GP. National patient survey data indicated patients rated the practice highly on continuity of care.
- The waiting area contained a wide range of information on services and support groups. This included well-presented and eye-catching display boards which provided information on a particular topic. For example, a board was designated to making health services young people-friendly, focussing towards confidential support for 14-19 year olds.
- A touchscreen check-in facility was available and a TV screen displayed information on health, local services, and appointments. A second waiting area was available on the first floor for patients being seen upstairs. No lift was available but there were very few services delivered from this floor and a consulting room could be provided downstairs should this be required.
- A separate room close to reception was usually used for private and sensitive discussions. When this was not available, patients were moved into a quiet area away from the main waiting area.
- The practice hosted a number of externally managed services on site to facilitate better access for patients. This included the health trainer; the Citizens Advice Bureau; substance misuse surgeries; and podiatry assessments for patients with diabetes.
- There were longer appointments available for patients who required them. Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Same day appointments were available for children and those patients with medical problems that required to be seen urgently.
- The practice provided care for residents across seven local care and residential homes for older people or people with a learning disability. We spoke to staff in four of these homes who informed us that the practice was highly responsive to their patients' needs. Urgent visits were done on the day as required and planned 'ward round' visits ensured patients were kept under regular review. The practice held meetings with the managers of care homes to review the service and discuss any difficulties which may have arisen.
- The practice provided primary care services for a local homeless centre.
- A substance misuse clinic was run jointly between a GP and the local service provider. The GP supported prescribing for the patients that accessed this service.
- The premises provided good access for patients in wheelchairs, or those with limited mobility. Most services were accessed on the ground floor. A hearing loop and available, although this was not routinely used. The practice flagged patients with visual impairment to ensure they received assistance, and some literature was available in larger font size and high contrast.
- Translation services were available for patients whose first language was not English. Information was displayed to assist patients to access interpreter services.
- The practice used letters with pictures and symbols to recall patients with a learning disability
- A 'Praise and Grumbles' box provided an opportunity for regular patient feedback. Comments were reviewed by the PPG and we saw evidence of changes that were

Are services responsive to people's needs?

(for example, to feedback?)

implemented as a consequence of comments received. For example, a concrete fill was added to the front threshold at the practice entrance to create a smooth ramp in response to comments from wheelchair users that this could be difficult to negotiate.

- There was a large and well-presented notice board for the PPG displaying information including 'you said...we did' to highlight the achievements made by the PPG as a consequence of patient feedback

Access to the service

The practice opened between 8am and 6.30pm Monday to Friday. The practice closed on one Wednesday afternoon each month for staff training.

GP appointments were available from 8.30am to 11.00am every morning, with additional appointments being provided at the end of the scheduled clinics to accommodate those patients with urgent needs. Afternoon GP appointments were usually available between 3.30pm to 5.30pm. Extended hours GP appointments were available at Avenue House every Monday evening from 6.30pm to 8.30pm, and extended hours early morning appointments were available on three days each week between 7am and 8am. The Hasland Surgery offered extended hours GP and nurse appointments every Monday evening between 6.30pm and 7.30pm.

In addition to pre-bookable appointments that could be booked up to two months in advance, urgent appointments were available for people that needed them.

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

- 85% of patients said they could get through easily to the practice by phone compared to the CCG average of 77% and national average of 73%.
- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 83% of patients with a preferred GP usually got to see or speak to that GP compared to a CCG average of 61% and a national average of 59%.

On the day of our inspection, we saw that the next available routine GP appointment was available in six days' time. The availability of appointments was closely monitored by the practice management and additional GP capacity was organised to address this as required (usually if waiting times extended to more than one week). Patients we spoke with on the day said they were usually able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints.
- Information was available to help patients understand the complaints system in the waiting area, and on the practice website.
- The practice undertook an annual review of complaints involving the practice team. This looked at any trends in the type of complaints received, and the learning which had been applied.

The practice had logged a total of 20 complaints received in the last 12 months and we found these were satisfactorily handled and dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints, and action was taken to as a result to improve the quality of care. For example, a complaint had arisen in providing personal information to reception staff when requesting an urgent GP appointment. This had been reflected upon and it was agreed that this question should still be asked of patients to ensure urgent appointments could be prioritised subject to clinical need. However, if a patient was not happy to divulge this information, then an appointment would be allocated but the GP would be alerted to discuss this with the patient to ensure that the system was not being used inappropriately.

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.

- The practice had developed a mission statement to ‘help the person by knowing the person’ reflecting their commitment to personalised care and continuity in seeing a named GP. Staff were aware of the statement and understood how it applied to their own roles.
- The practice held a short weekly meeting between the partners and practice management. This reviewed key issues including finance, service developments, and staff issues, including succession planning. In addition, two-hour monthly partners’ meetings were held and documented, to provide an opportunity to explore key issues in more depth.
- The partners did not have a written business plan as they considered that future planning was a live process, constantly affected by new demands. However, there was a clear strategy for the future and the partners were in discussions regarding developments for further potential expansion.
- The practice had been proactively involved in establishing the original local federated GP network and were now contributing to the development of new federated working arrangements with other practices.
- The partners planned for future developments and had engaged with their CCG and other local practices. For example, a GP and another locally based GP had initiated a meeting with colleagues in secondary care to discuss referrals and hospital discharge arrangements for all practices across the locality. Whilst the meetings were new, the liaison offered significant opportunities to progress more seamless working arrangements. Plans were being considered to mirror this arrangement in the north of the county between GP practices and their local acute hospital. The CCG were providing funding to support this development.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. All GP partners had designated managerial and clinical lead areas of responsibility. One GP attended quarterly CCG clinical governance meetings, and produced a written overview of the meeting for reference by the team.
- Practice specific policies were implemented and were available to all staff electronically.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of clinical audit and benchmarking against other local practices was used to monitor quality and to make improvements. The practice engaged with their CCG, and one GP had recently joined a group to assist with local clinical decision-making. The practice worked with other GPs in their locality, and via the practice managers’ forum, to share best practice and work collaboratively.
- Arrangements were in place for identifying, recording and managing risks, issues and implementing mitigating actions. For example, further to problems in accessing occupational health support for staff hepatitis immunisations, the practice had started to provide this service in-house for relevant staff members to ensure they kept staff and patients safe.

Leadership and culture

There was a clear leadership structure in place. The partners and practice management demonstrated they had the experience, capacity and capability to run the practice effectively and ensure high quality care.

- Following the successful merger of the two practices in April 2014, the partnership had achieved this without any significant financial impact. Arrangements were in place so that the practice management visited the Hasland site twice a week, with ongoing liaison in-between. GPs and staff at both locations communicated regularly and attended meetings and joint training events. The rotation of staff between sites was evolving and there was an intention to develop this further.
- The practice experienced a significant influx of new patients over the last two years further to a locally based issue. The practice demonstrated their resilience in managing change by accommodating this additional demand without disruption to their normal service.

Are services well-led?

Good 

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

- Staff told us the practice held weekly practice team meetings. This included all clinicians, practice management and representatives from the reception and administration team who then fed back to colleagues in their section. The pharmacist and district nursing team who worked with the practice were also invited to this meeting. Full staff meetings were incorporated into the monthly protected learning time if required. All staff received copies of minutes from these meetings to ensure they were informed of any outcomes.
- The practice held meetings for the nurses from both sites on a fortnightly basis. GPs had a 'coffee-break' session each week as an informal mechanism to catch up on any issues. Additionally, ad hoc training meetings took place to review the planning and co-ordination of the placements for GP registrars and medical students.
- Staff told us the partners were approachable and always took the time to listen to all members of staff. Social events took place throughout the year, and we observed strong and cohesive team working within the practice.

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

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

- The practice had gathered feedback from patients through patient participation group (PPG) involvement at events such as the annual flu vaccination programme; through patient surveys; via complaints received; from feedback received on the NHS Choices website; comments made via the practice's 'Praise and Grumbles' feedback system (with PPG involvement to review comments) in the waiting area; and responses received as part of the Families and Friends Test (FFT). The FFT is a simple feedback card introduced in 2013 to assess how satisfied patients are with the care they received, and results showed that 91% of patients were 'extremely likely or 'likely' to recommend the surgery to friends and families, since it was introduced.
- The PPG met bi-monthly with practice representatives in attendance. The PPG had a core membership of 15 patients with an extended virtual network which communicated via e-mail. The PPG told us that the practice listened to them; that they felt valued and

supported; and were actively involved with many aspects of the practice's work. The PPG had influenced several developments at the practice, and had a prominent display board in reception highlighting recent achievements. For example, the practice had changed the use of the TV screen in the patient waiting area to provide health messages and to use it as a visual and audible means of calling patients in to see the doctor.

- Staff said they felt respected, valued and supported, by the partners and managers in the practice, and felt involved and engaged to improve how the practice was run. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward-thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice had been a pilot site for community matrons, and had been integral in the development of bespoke care plans which were now used across the county. They had implemented schemes such as 24 hour ambulatory blood pressure monitoring (a way to monitor how a person's blood pressure fluctuates throughout the day and identify any situations where this may raise readings) before these became routine services provided by GP practices.

This history of innovative practice had been continued and the practice were currently involved in schemes to:

- Review the supply of incontinence products via a project involving the pharmacist and specialist incontinence nurse which was initiated by one of the GPs. This had produced good outcomes for patients and financial benefits for the CCG (almost £10,000 for this practice alone)
- Undertake a local pilot scheme to reduce the waste of repeated prescribed medicines. This was initiated by one of the GPs who had taken their proposal to the CCG prescribing lead. The CCG have agreed to fund this project which is planned to start in autumn 2016.
- Develop a standardised local notes summarising process. The intention of this was to establish a team of fully trained notes summarisers who would work across the local GP practices to ensure consistency.

Are services well-led?

Good 

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

The practice looked to the future and the potential for further mergers were under exploration. Whilst the benefits this produced in terms of economies of scale, the practice were mindful that this could only happen with practices which shared their own values and aspirations.