# Wellbrook Medical Centre

## Quality Report

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Date of inspection visit: 12 December 2017
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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 | Outstanding ☆ |
| Are services safe? | Good ● |
| Are services effective? | Outstanding ☆ |
| Are services caring? | Good ● |
| Are services responsive to people's needs? | Good ● |
| Are services well-led? | Outstanding ☆ |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

**This practice is rated as Outstanding overall.**
(Previous inspection in May 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Outstanding

Working age people (including those retired and students – Outstanding

People whose circumstances may make them vulnerable – Outstanding

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Wellbrook Medical Centre on 12 December 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes. Learning was shared with local practices where relevant.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- There was a nurse lead for infection prevention and control (IPC) which was managed effectively and seen as a high priority by all staff. IPC was a standing agenda item on nurse meetings and other clinical meetings.
- There was a system in place for receptionists to alert the duty doctor to any potential concerns about urgent symptoms such as chest pain or sepsis. There was a triage system in operation to prioritise those with an urgent need and all children under the age of five had their appointment fast-tracked if there was any concern.
- The GP lead for medicines management had provided monitoring and feedback on prescribing. Thishad resulted in reduced prescribing of certain antibiotics and painkillers.

# Summary of findings

- The practice used an electronic system to record and make patient referrals to secondary care. This enabled the referral letter to reach a consultant or service straight away and also made an entry into the correct patient record automatically.
- The practice utilised a Medical Interoperability Gateway (MIG) which enabled relevant patient information to be shared with other NHS organisations to ensure immediate access to medical records and a more efficient and effective treatment for patients who required secondary care. Patient consent was obtained before access.
- Nurses had attended training to perform annual atrial fibrillation (AF) reviews alongside INR/warfarin annual reviews and referred symptomatic patients and those at risk of developing heart failure to the GP.
- Nurses provided anti-coagulation clinics and used NICE 'Decision Aid' to support patients when starting anti-coagulation therapy. They also maintained the INR Star registers used for monitoring anti-coagulant medicines, and contacted any patients who were overdue a test or did not attend their scheduled appointment.
- Online appointments were used by 40% of patients at the practice. This was the highest uptake of online access within the CCG.
- The practice had planned to participate in a chaplaincy project in conjunction with the end of life team and a spiritual safe care champion from DCHS starting early in 2018.
- Patients had access to CAMHS RISE (Rapid Intervention Support and Empowerment) service for young people who were experiencing suicide ideation.
- The practice utilised an alert system on patient records which identified any additional needs. This enabled reception staff to support and signpost patients without causing embarrassment, for example; privacy to discuss issues, longer appointments, chaperone, assistance with reading information, carers support.
- The practice held regular fundraising events and encouraged social interaction with patients and visitors, for example; a Macmillan coffee morning was held to raise money for cancer.
- Staff told us about a number of examples where reception and other staff went that 'extra mile' to accommodate patients.
- The practice made reasonable adjustments when patients found it hard to access services. For example; availability of telephone appointments, support for self-management and immunisation clinics outside of core hours. Receptionists were flexible in the booking of appointments for patients around local bus times or transport arrangements, carers, and other needs, for example, needing a lift from a neighbour.
- The practice had a large number of patients on their register from the travelling community and all staff were aware of this patient group and the challenges they faced with regards to registering and accessing care. The practice took special care to assist where required.
- The practice were committed to the development of staff and had provided financial support for the practice nurse manager to work towards achieving an MSc in Advanced Practice over a period of three years. This training was to enable an extension of her role for the benefit of patients.
- The practice provided educational support in a local care home on a voluntary basis to enable staff to improve levels of care, and enable appropriate requests to the practice for urgent visits
- Patients identified as being frail had a clinical review which included a review of medication at a consultant-led multi-disciplinary clinic. The clinic was a single point of access where patients had all their needs assessed by health and social care professionals. Patients relatives and carers were invited to be involved in the care and transport was arranged where required. The initiative was due to be evaluated in March 2018.

We saw four areas of outstanding practice:

- The leadership and culture of this practice was one of continuous development with leaders having the expertise to influence and drive improvements in the delivery of patient care.
- The practice worked with the CCG pharmacist to review prescribing at care homes aligned to the practice. This resulted in changes to 638 prescriptions, which had resulted in a reduction in prescribing costs estimated to be approximately £57,000 per year.
- Regular monitoring and feedback on prescribing performance had led to an overall reduction in antibiotic prescribing by 11% in the preceding year, and prescribing of a particular painkiller had also reduced by 90% for acute prescribing and by 68% for repeat prescriptions.

# Summary of findings

- There was a large traveller community registered with the practice which included 21 children. We saw that 18 of these children were up to date with childhood vaccinations, apart from three who had declined the MMR vaccination. The parents for the remaining three children were in close contact with the health visitor who was working with the practice to encourage uptake.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

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

# Summary of findings

## Outstanding practice

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- Regular monitoring and feedback on prescribing performance had led to an overall reduction in antibiotic prescribing by 11% in the preceding year, and prescribing of a particular painkiller had also reduced by 90% for acute prescribing and by 68% for repeat prescriptions.
- There was a large traveller community registered with the practice which included 21 children. We saw that 18 of these children were up to date with childhood vaccinations, apart from three who had declined the MMR vaccination. The parents for the remaining three children were in close contact with the health visitor who was working with the practice to encourage uptake.

# Wellbrook Medical Centre

**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.

## Background to Wellbrook Medical Centre

Wellbrook Medical Centre (www.wellbrookmedical.co.uk) is registered with the CQC as a GP partnership with three GP partners. One of the GP partner is the registered manager.

The practice has a population of approximately 10,468 registered patients. The practice has a lower proportion of patients aged 65 and above in comparison to local and national averages, and a higher proportion of patients aged between 35 and 50 and a higher proportion of children.

The surgery provides primary medical services commissioned by NHS England and Southern Derbyshire Clinical Commissioning Group (CCG). The practice covers a predominantly rural area and is based in the semi-rural area of Hilton in Derbyshire and covers Hilton, Etwall, Hatton, Egginton, Burnaston and surrounding areas. The practice serves a relatively affluent population, and is ranked in the lowest decile for deprivation.

The practice team consists of the three GP partners and four salaried GPs (two males and five females). There are three practice nurses, one of whom works as the nurse manager and a healthcare assistant. The clinical team is supported by two practice managers and assistant practice manager and a team of reception and administrative staff.The clinical team are also supported by a community matron, who is based within the practice.

The practice extended the premises in October 2016, providing an additional four consulting rooms, a large treatment room, interview room, toilet and sluice.

The practice is open between 8am and 6.30pm Monday to Friday and from 8am to 12.15pm on Saturdays. Appointments are available from 8.30am to 12MD every morning and 3.30pm to 6pm daily. Late night appointments are available on Thursdays between 6.30pm and 8pm. Patients can book appointments with the GP up to four weeks in advance and with the nurse up to six weeks in advance. Out of hours appointments are available each evening until 8pm and on Saturday and Sunday mornings at one of the local hubs on a rotational basis. The Sunday hub is housed at Wellbrook Medical centre.

Patients are also directed to the out-of-hour's service provided by Derbyshire Health United when the practice is closed.

Good

# Are services safe?

## Our findings

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

**Safety systems and processes**

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

- The practice had a suite of policies and procedures to manage and monitor all their systems and processes. These were easily accessed via the practices computer system.
- The practice conducted safety risk assessments, including those for fire, Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings), and general health and safety issues. It had a range of safety policies which were regularly reviewed and staff received safety information as part of their induction and ongoing training programme.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. All staff received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns.
- The practice team worked with other agencies to support and protect patients from abuse, neglect, discrimination and breaches of their dignity and respect. We saw clear evidence of effective working with community based health and social care staff to achieve this aim. For example, there were regular meetings with health visitors and school nurses.
- Where children have missed more than one appointment, a GP will contact the parents or carer to discuss the reasons for not attending.
- Children who had attended accident & emergency on a regular basis were followed up by the practice to identify any potential safeguarding concerns.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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 who acted as chaperones were trained for the role and had received a DBS check.
- The nurse manager was the lead for infection prevention and control and there was an effective system to manage all activities and risk in relation to this. Regular audits were undertaken and any follow up actions that were identified were addressed promptly. Infection prevention and control was a standing agenda on nurse meetings and other clinical meetings.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems in place to support the safe management of healthcare waste.

**Risks to patients**

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Receptionists were able to alert the duty doctor to any potential concerns about urgent symptoms such as chest pain or sepsis. There was a triage system in operation to prioritise those with an urgent need and all children under the age of five had their appointment fast-tracked if there was any concern. Clinicians knew how to identify and manage patients with severe infections such as sepsis and had received sepsis identification training in the preceding year. A risk identification tool was used.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

**Information to deliver safe care and treatment**

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

Good

# Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- We reviewed a sample of referral letters and these included all of the necessary information. We saw that these were dealt with promptly and that there was no backlog of letters waiting to be progressed.
- The practice had fail-safe systems in place to ensure that any urgent incoming patient documents and pathology results were seen by the duty doctor and acted upon. Patients with abnormal results were contacted by a GP immediately to discuss their results. Routine test results were reviewed by a GP each day and the results shared with patients by text where they had signed up to this service. The clinical staff checked the patients telephone number each time a blood test was completed to ensure the result went to the correct person. Where patients did not respond to a request to make a follow up appointment, an administrator would telephone or write to them to remind them of this. If a second contact did not result in an appointment being made, a GP would review the results again and telephone the patient to discuss this.
- Female patients who attended for cytology screening were asked to check their patient identifier information was correct on the form and the specimen bottle, this was recorded in the patient record.

**Safe and appropriate use of medicines**

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. There was evidence of actions taken to support good antimicrobial stewardship. One GP partner acted as the prescribing lead and the practice worked with a medicines management pharmacist which ensured the practice was updated and adhered to high quality prescribing.
- Regular monitoring and feedback on antibiotic prescribing with a particular focus on restricted antibiotics (quinolones and cephalosporins) had reduced overall antibiotic prescribing by 11% in the preceding year. Prescribing of a particular painkiller had also reduced by 90% for acute prescribing and by 68% for repeat prescriptions.
- In May 2017, the practice implemented decision support software for prescribing. This provided 'point of care' messaging on locally aligned best practice to remind clinicians of safety and cost-effective prescribing.
- The practice had a robust and safe process to ensure any patients being prescribed high-risk medicines were being monitored closely. This was complimented by monthly searches of the patient care record system undertaken by the practice audit clerk to review that necessary monitoring was up to date and adhered to guidance.

**Track record on safety**

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Positive events were reported in recognition that learning from success was equally as important to drive improvements in quality.
- There were effective systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. These were discussed at practice meetings and reviewed again after three months. Learning was shared with staff and also

more widely where appropriate. For example; when the practice identified that a particular allergy was not being recognised by the computer system, they shared their learning with local practices who were using the same system.The issue was also raised with the system supplier and Southern Derbyshire Clinical commissioning Group (SDCCG) which was shared with CCGs nationally.

- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. Actions taken were discussed and logged.

Outstanding ☆

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice as outstanding for providing effective services overall and across all population groups except for older people, people with long - term conditions and people experiencing poor mental health.**

**Effective needs assessment, care and treatment**

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Clinicians were able to describe examples of recent discussions held in relation to new or updated guidance, and we saw that this was used to inform the practice's audit programme.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. There was use of individualised care planning with 80 active care plans in place for patients at the time of our inspection.
- 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.
- The practice used an electronic system to record and make patient referrals to secondary care. This enabled the referral letter to reach a consultant or service straight away and also made an entry into the correct patient record automatically.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice utilised a Medical Interoperability Gateway (MIG) which enabled relevant patient information to be shared with other NHS organisations to ensure immediate access to medical records and a more efficient and effective treatment for patients requiring secondary care. Patient consent was obtained before access.

Older people:

This population group was rated as good because:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication at a consultant-led multi-disciplinary clinic. The practice rotated with eight other local practices as part of an initiative to improve care for the elderly people who were frail. The clinic was a single point of access where patients had all their needs assessed by health and social care professionals. These included the community matron, care coordinator, nurse, physiotherapist, occupational therapist, and psychologist. Patients relatives and carers were invited to be involved in the care and transport was arranged where required. The initiative was due to be evaluated in March 2018. Initial patient survey data showed that 100% of patients were very happy with the service.
- The practice's computer system alerted staff to patients who were registered as being frail or vulnerable in other ways.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Monthly palliative care meetings were held with the care coordinator, community matron, social worker, Macmillan nurse, district nurses and practice staff to review the needs of elderly patients who were vulnerable and those receiving palliative care.
- The practice was aligned with four residential / care homes with a total of 150 patients. There was a GP lead for each of the homes who conducted monthly ward rounds.
- The practice worked with the CCG pharmacist to review prescribing at care homes aligned to the practice. This resulted in changes to 638 prescriptions, and 235 medicines were stopped where they were deemed to be unnecessary. This had achieved reductions in prescribing costs estimated to be approximately £57,000 per year.
- 75% of people over 75 had received an influenza immunisation in the preceding year. This was 5% higher than the national average.

People with long-term conditions:

This population group was rated as good because:

Outstanding ☆

# Are services effective?

## (for example, treatment is effective)

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. This included the health care assistant (HCA) who provided basic health assessments. Patients with more than one chronic illness were able to have all their conditions reviewed in one appointment.
- The practice nurse manager was the lead for long term conditions management and reviewed all test results and discharge letters prior to recording these in the patient records. Ongoing care was then discussed with nursing staff and GPs as required.
- They had achieved high rates for influenza vaccinations for people with a chronic illness in the preceding year. (COPD 100%; Diabetes 98%; CHD 98%; stroke 97%.)
- Nurses had attended training to perform annual atrial fibrillation (AF) reviews alongside INR/warfarin annual reviews. They assessed rate /rhythm control and identified those patients who were symptomatic or at risk of heart failure. Symptomatic patients were referred to the GP.
- Nurses provided anti-coagulation clinics and used NICE Decision Aid to support patients and guide them through the transition outlining the risks and benefits when starting anti-coagulation therapy. They also maintained the INR Star registers used for monitoring anti-coagulant medicines, and contacted any patients who were overdue a test or did not attend their scheduled appointment.

Families, children and young people:

This population group was rated as outstanding because:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above. They were proactive in following up non-attenders. The administrative team ran reports to check babies had their 1st/2nd/3rd Immunisations. Reports are run weekly for babies at 20 weeks and at 52 weeks and the administrator contacts parents if a child is missing any vaccinations. The administrator also alerts the nursing team who contact parents to discuss and encourage attendance.
- There was a large traveller community registered with the practice which included 21 children. We saw that 18 of these children were up to date with childhood vaccinations, apart from three who had declined the MMR vaccination. The parents for the remaining three children were in close contact with the health visitor who was working with the practice to encourage uptake.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- There was a sexual health service held at the practice run by Derbyshire Community Health Services (DCHS) where patients from other local practices could attend, and there was a C Card scheme in operation for teenagers. (The C-Card scheme is a community-based condom distribution scheme, which provides confidential access to free condoms, lube and dams, as well as sexual health advice and support to young people aged 13-19).
- Chlamydia testing kits were available for people under 25 years.

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

This population group was rated outstanding because;

- The practice's uptake for cervical screening was 96%, which was significantly higher than the national average of the 80% coverage target for the national screening programme. A longer appointment was provided for first time appointments to ensure adequate time for discussion and to help allay any anxiety.
- The practice's uptake for bowel cancer screening was 71% which was around 10% higher than the CCG average and 20% higher than the national average
- The nursing team discussed breast cancer and screening awareness at each cytology screening appointment. This had resulted in achieving 84% of available QoF points for breast screening for relevant female patients which was higher than both CCG and national averages which were 77% and 73% respectively.

Outstanding ☆

# Are services effective?

## (for example, treatment is effective)

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

This population group was rated as outstanding because:

- The practice worked closely with the community matron who provided support at home for some patients from the travelling community which included a patient who required palliative care.
- The practice were aware of other vulnerable groups and held a register of patients living in vulnerable circumstances including homeless people, patients at the end of their life, and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice were planning to participate in a chaplaincy project in conjunction with end of life team, and spiritual safe care champion from DCHS during early 2018.
- Patients with a learning disability were given longer appointments. The practice had recently implemented annual health checks, but had not had any responses from those patients invited at the time of our inspection.
- The practice utilised the 'Jo's Trust' initiative to support patients with a learning disability to attend for cytology screening by providing information booklets using large print with everyday words and pictures.
- The practice provided a substance misuse service on site with access to counselling where required.
- The practices computer system alerted staff to an additional needs that patients had to support them, including interpretation services, longer appointments, chaperone, transport and needle phobia.
- There was a domestic violence display board near to the patients toilets where patients could tear off the support contact details in private.
- Clinical staff were alerted about patients who did not attend for their scheduled appointment, these patients were reviewed and further action taken according to individual circumstances.

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

This population group was rated as good because:

The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example;

- 74% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average.
- The practice had received dementia friendly training and used an appointment reminder system for patients with memory problems. Receptionists would call the patient the day before and on the day of their appointment.
- There was a dementia friends poster displayed in the waiting area and a video played on the TV to alert people to the early signs of dementia.
- One of the salaried GPs who had received dementia training was the identified dementia champion at the practice and provided in-house and external training on dementia awareness
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is significantly higher than CCG and national averages which were 91% and 90% respectively.
- There was an alert on patients records to remind staff of any additional needs that patients had.
- There was a GP lead for mental health disorders.
- The practice held a register of patients who suffered with mental health disorders and had 42 patients on their list. They had started to invite patients on their register for a health review and out of 14 patients who had been invited so far, all 14 had attended.
- All staff had received training in mental health awareness.
- The percentage of patients who experienced poor mental health and had received discussion and advice about alcohol consumption was 92%. This was comparable to the national average.
- There was access to in-house CBT therapy and a counsellor.
- GPs had access to CAMHS RISE (Rapid Intervention Support and Empowerment) service for young people experiencing suicide ideation.

**Monitoring care and treatment**

Outstanding ☆

# Are services effective?

## (for example, treatment is effective)

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example; they had carried out more than 20 audits over the previous two years. These were a mix of clinical audits and prescribing audits and were driven by clinician interest, NICE guidelines and following significant events and patient feedback.

Clinical audit was seen as an important learning, monitoring and quality improvement tool within the practice and used audits to check quality of individual practice, make data integrity checks, check patient satisfaction of a new service, check clinical practice in a defined area, for example; cancer diagnoses, anti-coagulation therapy, minor surgery and referrals to other services.

We saw evidence of high quality audit activity and changes made to practice as a result of this work. For example; following an audit of ear irrigation procedures, the practice made a change which reduced the number of ear infections in patients following the procedure from 10.4% to 1.9% over a two year period.

The senior partner monitored prescribing practice and discussed findings with clinicians where relevant. This had reduced prescribing for non-steroidal anti-inflammatory medicines, some antibiotics and some anti-depressants to within acceptable levels of prescribing.

Where appropriate, clinicians took part in local and national improvement initiatives. For example; meningitis immunisations for under 25 year olds, NHS health checks, invitations for blood pressure checks for all patients over the age of 45 who had not had a check in last five years, participation in the diabetes prevention programme.

The practice had promoted the 'Pharmacy First' initiative which had recently been reintroduced in local area. (Pharmacy First is a local initiative where people can get advice, treatment with medicines, if needed, for a range of minor health conditions at local community pharmacists.Following an assessment at a participating pharmacy people who do not pay NHS prescription charges may be offered medicine, at no cost to the patient. And anyone who pays for prescriptions should find the cost of medicine is much less than a prescription charge)

The most recent published Quality Outcome Framework (QOF) results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 95%. The overall exception reporting rate was 13% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

**Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. All staff were encouraged to attend monthly QUEST sessions which were partly funded by the CCG and part funded by the provider. (The provider funded the out of hours service to enable the practice to close one afternoon each month for learning and development) The CCG funded four of these events each year.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach 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.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

Outstanding ☆

# Are services effective?

## (for example, treatment is effective)

- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There was a care coordinator based at the practice and all staff referred patients to her, including reception staff who sometimes identified that patients or carers were struggling to cope physically or emotionally.

**Helping patients to live healthier lives**

Staff were consistent and proactive in helping 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 health. For example; there was access to smoking cessation and weight management advice on site with regular visits from the Live Life Better Derbyshire service.
- The practice supported some patients to self-manage and monitor their condition through telephone assessments and information packs.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

**Consent to care and treatment**

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

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

Good

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, as good for caring.**

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff had received training in equality and diversity and understood patients' personal, cultural, social and religious needs. For example; ensuring that transgender patients were addressed them correctly according to how they are dressed, using their appropriate names.
- The practice team were encouraged to get to know the patients and share relevant information with the team to enable better care and help.
- Staff were encouraged to 'place themselves in the patient's shoes'.
- The practice utilised an alert system on patient records which identified any additional needs. This enabled reception staff to help patients without causing embarrassment, for example; privacy to discuss issues, longer appointments, chaperone, assistance with reading information, carers.
- The practice gave patients timely support and information.
- 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.
- All of the 39 patient Care Quality Commission comment cards we received were positive about the service experienced. However, 10 of these also commented that it was challenging to get a routine appointment. This was is in line with the results of the NHS Friends and Family Test and other feedback received by the practice where patients were very positive about the care they had received.

We were told about examples where reception and other staff went that 'extra mile' to accommodate patients. For example;

- Reception staff were alerted to patients who had booked 'on the day' appointments and failed to turn up. They would call the patient to check on their welfare.
- A very frail elderly patient had been brought to the practice by a member of the public who had witnessed them have a bad fall. The reception team organised for a member of staff to take the patient to their home address.
- The practice staff regularly offered patients with mobility problems assistance in getting to the clinical rooms and offered a wheelchair service if required.
- Staff members would take the wheelchair to the car park and meet patients and help bring them in to the surgery to attend for their appointment.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 235 surveys were sent out and 107 were returned. This represented a 46% response rate. The practice was average for its satisfaction scores on consultations with GPs and above average for nurses. For example:

- 86% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 84% of patients who responded said the GP gave them enough time; CCG - 87%; national average - 86%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 82% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 93% of patients who responded said the nurse was good at listening to them; (CCG) - 92%; national average - 91%.
- 95% of patients who responded said the nurse gave them enough time; CCG - 92%; national average - 92%.

100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.

- 95% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 79% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average - 87%.

**Involvement in decisions about care and treatment**

Good

# Are services caring?

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids 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 patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 140 patients as carers, including young carers. (1.4% of the practice list).

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.
- Reception staff routinely referred patients to the care coordinator if they thought they may be caring for someone and if they appeared to be struggling physically or emotionally.
- Carers were discussed at practice meetings as a quarterly agenda item so that the needs and provision for this group could be regularly reviewed and discussed.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.
- The practice identified recently bereaved patients to relevant staff, including the reception staff. This made staff aware of additional sensitivity required for these patients when attending the practice.
- The practice worked with a local charity who provided food hampers to distribute to selected vulnerable patients at Christmas This was led by the care coordinator. Reception staff identified people who would benefit from this and practice staff delivered the hampers in person.

The practice regularly held fundraising events and encouraged social interaction with patients and visitors, for example; Macmillan coffee morning to raise money for cancer, where staff baked cakes and ensured gluten free or diabetic options were available.

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

- 88% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 86% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 83%; national average - 82%.
- 93% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 87% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

**Privacy and dignity**

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice, and all of the population groups, as good for providing responsive services across all population groups except for vulnerable people, which we rated as outstanding for this group.**

**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. For example;

- They provided extended opening hours which included access to a local hub, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice made reasonable adjustments when patients found it hard to access services. For example; telephone appointments were available, support for self-management, immunisation clinics outside of core hours. Receptionists were flexible in the booking of appointments for patients around local bus times or other transport arrangements, carers, and other needs, for example, patients who required a lift from a neighbour.
- There were dedicated anticoagulation monitoring clinics which had been extended to better accommodate working patients.
- Audiology clinics were located on site and provided hearing assessments for the over 55s with provision of hearing aids as appropriate.
- Abdominal aortic aneurism (AAA) screening was located on site to encourage attendance.

Older people:

This population group was rated as good because:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice provided care for residents at two nursing homes and two local care homes. Monthly visits were made to the homes by a named GP and any urgent requests were responded to on the day. We spoke with managers from two of the homes who told us that the care each GP provided was 'fantastic' and they could not speak highly enough about the practice. GPs took time with patients and participated in best interest assessments and advance planning arrangements whenever necessary.

The practice had identified unsatisfactory care being delivered in a local care home and had responded to this by providing educational support on a voluntary basis to help staff improve their knowledge and skills in assessing patients urgent health needs. This had resulted in more appropriate requests for urgent visits to the home and less innapropriate requests. This had reduced the workload for GPs and had improved care for residents.

- Phlebotomy appointments were held in a consulting room closest to the waiting area.
- The practice liaised with local teams to provide a falls recovery service.
- They provided a single point of access clinic for patients who were known to be frail.

People with long-term conditions:

This population group was rated as good because:

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

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- An alert system had recently been introduced to identify patients who ordered more than three short acting bronchodilator inhalers in the last 12 months. Receptionists receiving medication requests would alert the nurse manager, who reviewed patient notes and invited them to come in for an additional appointment to check whether their condition was being controlled.
- The practice were aware of their practice population and accommodated some patients who wished to monitor their own condition. They offered telephone assessments where appropriate and had implemented self-management plans for selected patients with a diagnosis of asthma, COPD and diabetes.
- The practice had developed individualised care plans for these patients which were copied into patient records. The care plans were reviewed regularly and updated in line with current NICE guidelines. Where appropriate the care plans detailed signs of deterioration, who and when to contact or first steps in self- care including potential life threatening situations.
- The practice were proactive in diagnosing pre-diabetes and referred patients to the 'Healthier You' programme. They had referred 52 patients in the preceding year.
- The practice worked closely with specialist nurses to provide expert advice for those patients that required it.
- There were plans to host the diabetes expert programme at the practice from 2018.(a six-week programme of education for patients with diabetes to learn how to manage their condition).

Families, children and young people:

This population group was rated as good because:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary. Children under 5 were seen as a priority.
- There was a Community Sexual Health Clinic located on site which provided appointments and a drop-in service for patients and other local people.
- Sexual Health and contraception advice/ methods are discussed /offered opportunistically or at immunisation update for the Under 25's.
- Due to increasing demand, the nurse manager undertook training and assessment for the insertion and removal of subdermal contraceptive implants. This had the benefit of increasing access to this service and reducing the need for GPs to perform this task. Counselling was provided for all contraceptive needs.

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

This population group was rated as good because:

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

- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Extended hours clinics were available on Thursday evenings and Saturday mornings. Access to extended hours 'hub' services were also available at one of the nearby practices outside of core hours.
- Online appointments were used by 40% of patients at the practice. This was the highest uptake of online access within the CCG.
- Immunisation clinics were extended to 6pm for working parents in response to patient feedback.
- Anti-coagulation monitoring clinics were extended to 6pm for working people following feedback from patients.
- The practice offered a range of services which included travel vaccinations, family planning, sexual health, blood tests, 24 hour blood pressure monitoring, smoking cessation, spirometry (a test used to help diagnose and monitor certain lung conditions), and electrocardiogram (an ECG is a simple test that can be used to check a patient's heart's rhythm and electrical activity).

People whose circumstances make them vulnerable:

This population group was rated outstanding because:

They had identified a particular vulnerable group who were not accessing the healthcare they required and had worked with them to help them understand the importance of vaccinations, health screening and attending for treatment when required.The practice had a large number of people

on their register from the travelling community and all staff were aware of this patient group and the challenges they faced with regards to registering and accessing care, and took special care to assist where required. For example;

- Receptionists would offer to help with completing registration forms and other documentation in a private area.
- An alert was set up on the patients record indicating any additional help required.
- They offered to contact patients by phone to remind them of their appointment.
- Staff were aware of the challenges some of the patients faced in keeping to an appointment time and so appointments were fitted in on the same day where possible to ensure they were seen.
- They provided picture based resources to help patients who were unable to read.
- The practice provided DVDs to explain the importance of childhood immunisation and encourage compliance. This had led to an increase in uptake.
- Labels were printed for specimen bottles so that there was no need to write the details.
- The practice liaised with a dedicated health visitor for travellers and other vulnerable people.

The practice held a register of all patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

- They encouraged ladies with a learning disability to attend for cytology screening by offering a longer appointment and utilised information booklets with large print using everyday words and pictures to help the patient to understand the procedure and to alleviate anxiety.
- The practice participated in a revised Learning Disabilities enhanced service and had provided training for all practice staff. The first HCA led learning disability health checks were due to commence early December 2017.

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

This population group was rated as good because:

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- The practice had dementia friendly status and the practice team had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held a register of patient who had a mental health disorder and offered an annual mental health review. They had completed 14 of these in the preceding year.

**Timely access to the service**

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 235 surveys were sent out and 107 were returned. This represented about 46% of the practice population.

73% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.

- 50% of patients who responded said they could get through easily to the practice by phone; CCG – 67%; national average - 71%.
- 82% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 84%; national average - 84%.
- 72% of patients who responded said their last appointment was convenient; CCG - 81%; national average - 81%.
- 54% of patients who responded described their experience of making an appointment as good; CCG - 71%; national average - 73%.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- 65% of patients who responded said they don't normally have to wait too long to be seen; CCG - 61%; national average - 58%.

The practice had improved it's telephone messaging system and it was noted that on every occasion where the inspection team contacted the practice, there was no delay in answering our calls or in being directed to a service or individual.

**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 and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 24 written complaints were received in the last year. We reviewed some of these complaints and found that they were satisfactorily handled in a timely way. Verbal complaints were also recorded and we saw that these were usually resolved within two days.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example; when an immunisation error occurred, the practice made a minor amendment to practice and learning was shared with all staff.

# Are services well-led?

Outstanding ☆

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

## Our findings

**We rated the practice, and all of the population groups, outstanding for providing a well-led service.**

**Leadership capacity and capability**

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

- Leaders had the experience, capacity and skills to deliver the practice strategy. Clinical leadership was directed by GPs who undertook specific lead responsibilities such as prescribing, QOF, palliative care, mental health and safeguarding.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. They had resolved clinical capacity issues by recruiting two additional salaried GPs. They had increased nurse capacity by 53% and HCA capacity by 25%. Secretarial capacity had increased by 23% and practice management capacity by 50% strengthening the business management/strategic and leadership function during the preceding year.
- The practice participated in a NHSE clinical pharmacist pilot which had led to the recruitment of a clinical pharmacist in January 2017 who also worked with another local practice. The clinical pharmacist assisted in reviewing prescription changes, medicines optimisation reviews and making records searches where required to follow up on medicines safety alerts.Recruitment of second clinical pharmacist was planned for in early 2018.
- The practice had re-branded the receptionist role to practice administrator in recognition of the changing nature of general practice and the requirement to adapt from the traditional receptionist role. Each team had a senior person to manage and lead them.
- There was a planned trial of advanced clinical practitioner (ANP) to work alongside GPs to provide support with telephone triage and minor illness clinics during the winter period. This was allied to the Place ANP initiative.


- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

**Vision and strategy**

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. This was displayed in the practice.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice were aware of the needs of its population and planned its services to meet these needs.
- The practice monitored progress against delivery of the strategy.

**Culture**

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. We saw evidence to confirm this when reviewing incident reports.
- The practice promoted a culture of 'no-blame' for reporting concerns and significant events. This enabled discussion of what went wrong so that learning points could be shared to ensure, that the likelihood of a similar event occurring is minimised.
- The practice encouraged staff to 'look outside the box' to encourage innovative thinking about new ways of improving services, keeping patients safe and ensuring clinical governance.

# Are services well-led?

Outstanding ☆

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

- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Staff told us about a number of situations where the practice had supported them personally and professionally through various challenges. Staff were overwhelmingly positive about the care and support that was offered to them.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training and felt they were treated equally.
- There were positive relationships between staff and all teams. This included the attached staff, some of whom had chosen to use the practice as a base.

**Governance arrangements**

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There was a schedule of regular in-house meetings.
- One of the GP partners had previously held a strategic lead role within the clinical commissioning group (CCG) and continued to use this knowledge and expertise to influence and drive improvement in the delivery of patient care within the locality.
- Although the practice was not formally a training practice for GPs, there was a clear culture of learning and development which extended across all roles.

**Managing risks, issues and performance**

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. This included where patients had been discharged from secondary care. Where concerns about poor care had been identified for example; unsatisfactory discharge plan, these were followed up with individual patients to ensure safety, and reported to the CCG clinical quality team so that discharge plans could be improved.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.
- The practice employed a data administrator to run weekly and monthly checks and reports on patients who had not attended for a scheduled appointment for a health check, medicines review, screening, test or immunisation at the practice and also those who had not attended for tests or secondary care referrals. These were followed up with phone calls and where relevant escalated to the nurse manager or a GP.
- The practice utilised a suite of data extraction tools to identify potential issues such as fragility fractures and patients who were not complying with treatment.

# Are services well-led?

Outstanding ☆

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

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

**Engagement with patients, the public, staff and external partners**

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example; changes to appointments system and later immunisation clinics for working parents.
- There was an active patient participation group. We spoke with a member of the PPG who informed us that the PPG had quarterly meetings with practice representatives. The PPG representative told us that the group was treated respectfully and was listened to by the practice. The practice was open with them when things had gone wrong and that they were consulted on issues that impacted upon patients.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice were proactive in sharing lessons learned from significant events with other local practices where they might benefit.

**Continuous improvement and innovation**

There was a focus on continuous learning and improvement at all levels within the practice. For example;

- The practice provided financial support for the practice nurse manager to work towards achieving an MSc in Advanced Practice over a period of 3 years. This training was intended to extend her role with further development planned for the future.
- The practice also supported the practice nurse manager in completed training in the fitting and removal of contraceptive implants. This enabled an alternative to this service being provided by a GP, improving access to this service for patients.
- The practice also enabled the practice nurse manager to complete a leadership and management course further training to become an accredited practitioner in the provision of anti-coagulation monitoring services. This had enabled increased access to this service for patients.
- Mental health awareness training introduced for all practice staff
- Organisation of a practice 'away day', funded with resilience monies, to help strengthen team spirits and focus on shared goals and positivity.
- Practice funding of additional educational sessions (Quest) events
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

The practice were committed to participating in local improvement initiatives, for example;

- They worked in collaboration with other local practices as part of a CCG PLACE initiative to share best practice and improve access, services and outcomes for patients.

# Are services well-led?

Outstanding ☆

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

- They participated in a diabetes 'proof of concept' initiative, focusing on a minimum of 5% improvement in achievement of treatment targets for blood sugar levels, blood pressure and cholesterol.
- The practice had played a lead role in organisation and management of Place Frailty Clinics and offered a 'one stop shop' multi-disciplinary, consultant-led service which was provided at each practice within PLACE on a rotational basis. This service was due to be reviewed and audited.
- They participated in a local pilot to provide extended access for nine practices in Derby City South Healthcare PLACE. The extended hours hubs offered appointments on each evening, Saturdays and Sundays.
- The practice were planning to provide additional chronic disease management clinics at PLACE level.
- There were plans to participate in a pilot, due to commence in early 2018, of a 'Medicines Order Line' for the processing of repeat prescriptions, to help with efficient processing, reduction of inappropriate requests and wastage.