Ripley Medical Centre

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ripley Medical Centre on 10 May 2016. Overall the practice is rated as good

The practice had recently undergone a change to their management structure. This had changed from a GP Partnership to Derbyshire Community Health Services (DCHS) NHS Foundation Trust from 6 April 2016.

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 from events was applied to enhance the delivery of safe care to patients.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. The practice was committed to staff training and development and the practice team had the skills, knowledge and experience to deliver high quality care and effective treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. The practice responded to feedback received from patients.
- A wide range of literature and information about local services and health-related issues was available in the waiting area.
- Verbal information was provided to patients about how to make a complaint, but there was no information about this on display in the waiting area. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they generally found it easy to make a routine appointment with a GP and appointments were available the same day for all patients through the use of a 'sit and wait' system. However, this sometimes meant that patients waited up to two hours.
- The practice ensured they engaged with vulnerable patients to provide them with the support they needed. This included having a more flexible approach to consulting with them to ensure they could receive the care they required.

Summary of findings

- The practice had excellent facilities and was well-equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff told us that they felt supported by management.
- The practice reviewed the skill mix of their team to meet their patients' needs. For example, they had recently appointed an additional full time salaried GP and were actively recruiting an advanced nurse practitioner (ANP)
- The provider had reviewed their contingency arrangements. For example, they were in the process of recruiting bank practice nurse staff to ensure continuity of service during staff leave.
- There was an active patient participation group which worked with the practice for the benefit of patients. For example, they conducted a patient survey following changes to the appointments system.

The areas where the provider should make improvement are:

- The provider should ensure sufficient training and guidance is in place to support staff to understand and fulfil their role as chaperones, including where to stand during an examination.
- The provider should review their delivery of training to enable staff to complete training they deem mandatory within the timescales set.
- The provider should consider increasing the availability of bookable appointments
- The provider should consider reviewing their systems for recalling patients with chronic diseases to include alternative methods of contact.

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?

Requires improvement

- 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.
- When any unexpected safety incidents occurred, people were provided with an explanation and an apology. They were told about any actions to improve processes to prevent the same thing happening again.
- 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.
- Risks to patients and the public were generally assessed and well-managed including procedures for infection control and other site-related health and safety matters. There were systems in place to ensure adequate cleaning, however there were no written cleaning schedules in place.
- Medicines, including vaccines and emergency medicines, were generally stored safely and appropriately with good systems to monitor and control stock levels.
- Patients on high risk medicines were monitored on a regular basis and actions were taken to review any medicines alerts received by the practice to ensure patients were kept safe.
- The practice had effective systems in place to deal with medical emergencies.
- Staff had received training in basic life support during their induction. All staff with the exception of the apprentice who took up post in February 2016, had completed an annual update in the preceding 12 months. Further life support training was planned in October 2016.

Are services effective?

Good

- The practice adhered to local and NICE guidance, for example when treating patients for the management of long-term conditions.
- Data showed patient outcomes were generally above average for the locality. The practice had achieved an overall figure of

Summary of findings

99.5% for the Quality and Outcomes Framework 2014-15. This was 2.5% above the CCG average and 4.8% above the national average. The exception reporting rate at 9% was broadly in line with local and national averages.

- Clinical audits demonstrated quality improvement, and we saw examples of audits that had produced positive outcomes in patient care and treatment. We saw one that had been conducted over two cycles
- Staff had the skills, knowledge and experience to deliver effective care and treatment. GPs had specific areas of interest and acted as a resource for their colleagues.
- All staff had received a general induction, and clinical staff had received a robust role specific induction. All staff had received a performance review in the last 12 months which included an analysis of their training needs but not all staff had received training the provider considered to be mandatory.
- Staff had received training appropriate to their role, however, there were a number of clinical and non clinical staff who had not completed statutory and mandatory training updates.
- 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.
- Staffing needs were kept under review to ensure the needs of patients could be effectively fulfilled.

Are services caring?

Good

- We observed a strong and visible patient-centred culture. Staff were motivated to offer personalised care that promoted people's dignity. 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.
- Data showed that patients generally rated the practice in line with local and national averages in respect of care. For example, 87% said the GP was good at treating them with care and concern compared to the CCG average of 86%, and the national average of 85%.

Summary of findings

- The practice adopted a flexible approach in dealing with vulnerable patients to ensure their individual needs were accounted for. This included seeing patients opportunistically at short notice in recognition that some patients found it difficult to engage with health care.
- The practice manager had been assigned as the practice carer's lead. The practice were proactive in identifying patients who were also carers and provided a range of support for them, including access to a wellbeing worker and a 60 minute carers' clinic appointment.
- 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.
- The practice provided personalised care to those patients at end-of-life. Practice data showed that 47% 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. Those who did not die in their preferred place were supported to die in the most appropriate place according to individual need.

Are services responsive to people's needs?

Good

- The practice operated a morning 'sit and wait' clinic offering open access to all patients. All patients arriving before 10.30am would be seen by a GP. However, patients had to wait for up to two hours to see a GP under this system. Patients we spoke with had mixed views about this system.
- Bookable GP appointments were provided each afternoon. However, these could only be booked two weeks ahead, with one day's appointments being released each day.
- Comment cards and patients we spoke with during the inspection were generally positive about their experience in obtaining a routine appointment. This was reinforced by the national GP survey in January 2016 which found 75% patients described their experience of making an appointment as good. This was in comparison to a CCG average of 73% and a national average of 73%.
- The practice hosted a range of services on site which made it easier for their patients to access. This included a weekly clinic provided by a consultant psychiatrist; and a weekly Citizens Advice Bureau session to assist with benefits advice
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.

Summary of findings

- The premises provided modern and clean facilities 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 27 residents in a local care home. We spoke with staff in the home who informed us that the practice was very responsive to their patients' needs. Urgent visits were done on the day when required and weekly 'ward round' visits ensured patients were kept under regular review.
- Information about how to complain was available on speaking to a receptionist, however there was no written information or poster displayed in the waiting area. The practice responded quickly when issues were raised and learning from complaints was shared with staff to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they were offered a private room next to the waiting area.

Are services well-led?

Good

- The GPs had a vision to deliver high quality care and promote good outcomes for patients. Practice values had been recently revised with practice staff and underpinned the practice's work and staff were clear about their responsibilities in relation to this.
- 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 provider, Derbyshire Community Healthcare Services NHS Trust (DCHS) encouraged the practice to maintain its own identity as it was now integrated into a much larger organisation. DCHS also actively encouraged ongoing collaboration with other local practices and the CCG.
- The recent change in leadership structure provided benefits such as Human Resources support for staff recruitment processes; and access to DCHS training programmes.
- Staff felt supported by the practice management team and generally looked forward to changes and improvements that working within a larger team might provide. The practice held regular staff meetings.
- The GPs reviewed comparative data provided by their CCG and ensured actions were implemented to address any areas of outlying performance.

Summary of findings

- The practice had developed a range of policies and procedures to govern activity although these were now in the process of review to ensure they were in alignment with the new provider.
- The practice sought feedback from patients and staff, which it acted on to improve service delivery.
- The patient participation group (PPG) helped inform practice developments, for example, by providing communication for patients regarding changes

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 a higher proportion of older people registered with them compared to local and national averages. The practice had 10.1% of their patients aged 75 and over (local 7.9%; national 7.8%)
- The practice provided personalised care for all their patients, and each patient was allocated a named GP responsible for the co-ordination of their care.
- The practice held monthly multi-disciplinary meetings to review the needs of patients with complex needs and to review and update care plans.
- The practice worked with a named care co-ordinator to plan and deliver care for the most vulnerable patients and those at risk of hospital admission. The practice ensured contact was made with patients discharged from hospital within three days to ensure they were safe and well.
- The facilities were located at ground floor level with wide access corridors and spacious consulting rooms, suitable for wheelchairs and mobility scooters.
- The practice used bespoke care plans to provide clear information on individual care plans, including patient preferences. This information sharing with out of hours' services and other agencies provided 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 one local residential home. A named GP provided weekly visits to the care home for continuity. The visits provided medical advice, reviews of patients' medicines, care planning, and the discussion of any safeguarding concerns. The practice responded to any urgent patient needs on the same day.

People with long term conditions

Good

- QOF achievements for clinical indicators at 99.5% were higher than CCG and national averages (97% and 94.7% respectively)

Summary of findings

- The practice undertook annual reviews for patients on their long-term conditions registers. The review occurred in the patient's birthday month and included a review of each patient's prescribed medicines. An additional review was usually conducted after any hospital admission.
- NHS health checks were provided to assist in the early identification of chronic disease to enable early intervention and treatment where this was required.
- There were nurse-led clinics available to support patients with diabetes, asthma and chronic obstructive airways disease. Appointments ranged from 20 minutes to 45 minutes according to individual need and patients were encouraged to contribute to their individual care plan. Condition-specific information was provided which included advice on how to recognise worsening of the condition and action to be taken.
- The practice was committed in supporting the training of clinical staff to deliver excellent chronic disease management. For example, the practice was supporting a nurse to attain a diploma in diabetes, and the health care assistant had completed a course to enhance their skill set in supporting those patients with a long-term condition. A monthly diabetes clinic was attended by a Diabetes Specialist Nurse from the locality, to support the practice nurses in developing their skills in this condition. This also had the benefit of reducing the usual four week wait for patients with complex diabetes symptoms to be seen in the community.
- INR monitoring was provided at the practice and within patients' 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 had developed their own patient advice and information leaflets including diabetes, spirometry (a breathing test), and the application of ear drops.
- A pharmacist from the CCG's medicines management team visited the practice weekly to assist with medicines audits, reviews of prescribed medicines, and offered prescribing advice and guidance.

Families, children and young people

Good

- Quarterly meetings were held with health visitors, school nurses and other community based agencies to safeguard children and support families in need.

Summary of findings

- The practice provided same day open access consultations each morning. Telephone advice was offered to parents, and appointments were provided outside of standard school hours.
- A family planning service was provided including intra-uterine device (coil) and implant fittings. The practice also provided a sexual health clinic and emergency contraception.
- 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 upon request.
- The practice hosted weekly midwifery and monthly health visitor clinics.
- Childhood immunisation rates for the vaccinations given were comparable to CCG averages. Monitoring of these recalls was in place to keep children safe.

Working age people (including those recently retired and students)

Good

- The practice provided daily same day appointments each morning on a 'sit and wait' basis. Telephone consultations were available each morning and afternoon which had to be booked in advance. No extended hours' GP appointments were available.
- The practice offered on-line booking for all GP pre-bookable 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.
- Streamlined questionnaire-based were available for non-complex medicines reviews, so that the patient did not have to attend the practice.
- 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, the practice had achieved a rate of 83.9% cervical screening for eligible women which was higher than local and national averages (77.7% and 74.3% respectively)

People whose circumstances may make them vulnerable

Good

- The practice provided health checks for patients with a learning disability with their practice nurse. The practice had undertaken an annual health review in the last 12 months for 57% of patients with a learning disability.

Summary of findings

- A more flexible appointment system was offered to vulnerable patients when required
- The practice worked in–line with recognised standards of high quality end of life care. Palliative care was co-ordinated by a named GP working with the wider multi-disciplinary team. Bi-monthly palliative care meetings were in place between with GPs, 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. The analysis included whether or not the patient had died in their preferred place.
- The practice adopted a co-ordinated approach to care by the use of care plans, which ensured key information was shared with other providers such as the out of hours service.
- Homeless people were welcomed to register with the practice.

People experiencing poor mental health (including people with dementia)

Good

- The practice achieved 100% for mental health related indicators in QOF, which was 3.1% above the CCG and 7.2% above the national averages, with exception reporting rates generally in line with averages.
- 97% of patients with ongoing active mental health problems had received an annual health check during 2014-15, and this was achieved with a significantly lower exception reporting rate than local and national averages.
- 91.8% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was higher than local and national averages, with similar exception reporting rates.
- The practice provided information to patients on how to access locally based talking therapy services.
- The practice identified carers and sought patient consent to discuss care with their carer directly.
- Plans were in progress for the community psychiatric nurses to provide weekly clinics at the practice to support patients experiencing poor mental health.
- Patients could self -refer to confidential counselling sessions with Talking Mental Health which were held on at the practice

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 generally performing in line with local and national averages. A total of 243 survey forms were distributed and 100 were returned, which was a 41% completion rate of those invited to participate.

- 82% of patients found it easy to get through to this surgery by phone compared to a CCG average of 74% and a national average of 73%.
- 86% of patients were able to get an appointment to see or speak to someone the last time they tried in line with the CCG average of 86% and the national average of 85%.
- 93% of patients said the last appointment they got was convenient compared to a CCG average of 92% and a national average of 92%.
- 75% of patients described their experience of making an appointment as good compared to a CCG average of 73% and a national average of 73%.
- 93% of patients found the receptionists at this surgery helpful compared to a CCG average of 88% and a national average of 87%.
- 38% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 69% and a national average of 65%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 15 comment cards which were all extremely positive about the standards of care received from the GPs and the nurses. Patients commented that they were treated with respect and were given sufficient time to discuss their health problems. Patients also said that the reception team were very helpful and courteous, and many noted the high standards of cleanliness within the practice. However, four cards included some negative feedback about waiting times for appointments.

We spoke with eight patients during the inspection. All of the patients we spoke with said that they were treated with dignity and respect by all practice staff; that they were provided with sufficient consultation time; that scheduled appointments ran on time; and that the practice was always clean and tidy. The majority of the eight patients reported satisfaction with the appointment system, and were provided with explanations on treatment options during consultations.

Some patients raised a concern with regards continuity in seeing the same GP, although there was an acknowledgement by most that they may have to wait longer to see a GP of their choice. The practice was aware of this issue and had appointed a new salaried GP who was due to start soon. It was hoped that this may help to improve this situation, as well as create increased access to GP appointments generally. They were also actively recruiting an advanced nurse practitioner to provide additional appointment sessions for minor illness.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The provider should ensure sufficient training and guidance is in place to support staff to understand and fulfil their role as chaperones, including where to stand during an examination.
- The provider should review their delivery of training to enable staff to complete training they deem mandatory within the timescales set.
- The provider should consider increasing the availability of bookable appointments
- The provider should consider reviewing their systems for recalling patients with chronic diseases to include alternative methods of contact.

Ripley 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, a second CQC inspector, 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 Ripley Medical Centre

Ripley Medical Centre provides care to approximately 5,215 patients residing in the areas of Ripley, Heage, Swanwick, Loscoe and Codnor, located within Derbyshire. The surgery provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England, and services commissioned by NHS Southern Derbyshire Clinical Commissioning Group (CCG). The practice operates from a purpose-built building, and is planning refurbishment work in the near future.

The practice has been run by Derbyshire Community Health Services (DCHS) NHS Foundation Trust since 1 April 2016. The practice has four part-time GPs (two males and two females) equating to 3 whole-time GPs. A further part-time female GP has been recruited and will commence work at the practice in June 2016.

Ripley Medical Centre is an established training and teaching practice and accommodates GP trainees (a qualified doctor who is completing training to become a GP); and medical students. However, at the time of our inspection, the practice was temporarily not supporting trainee placements due to the recent integration process with DCHS. It planned to re-instate the trainee programme later in 2016.

The practice employs one full-time practice nurse and a full-time health care assistant. The clinical team is supported by a practice manager and deputy manager, and a team of seven administrative and reception staff, including a full-time apprentice post.

The registered practice population are predominantly of white British background. The practice age profile has higher numbers of patients aged over 45 and this is more pronounced for patients aged 75 and over (10.1% compared to the CCG average of 7.9%, and the national average of 7.8%).

The practice opens from 8am until 6.30pm Monday to Friday. GP morning consultation times operate on a 'sit and wait' basis between 8.30am and 10.30am, and bookable afternoon surgeries run from 3pm to 5.30pm. Telephone consultations with patients are also available. The practice closes one afternoon each month for staff training. There are no extended hours' appointments available.

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 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 Southern Derbyshire CCG to share what they knew.

We carried out an announced inspection on 10 May 2016 and during our inspection:

- We spoke with staff including GPs, the practice manager, the assistant practice manager, practice nurses and four members of the reception and administrative team. In addition, we spoke with representatives from three local care homes and members of the community nursing team regarding their experience of working with the practice team. We also spoke with eight 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

· 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)

Requires improvement

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents that occurred. A paper form was available to report incidents.
- The practice manager reviewed all non-clinical significant events whilst a GP reviewed clinical incidents. Incidents were investigated with the individuals concerned and then reviewed at staff meetings which were held each month. Any incidents requiring urgent attention were dealt with immediately, and a risk rating was applied to each incident to assess the potential impact these presented to the practice and staff.
- When there were unintended or unexpected safety incidents, people received support, information, an apology, and were told about any actions taken to prevent the same thing happening again.
- The practice promoted a 'no blame' culture and supported staff who had been involved in an incident.

We reviewed a selection of incident forms from the 18 significant events recorded by the practice team over the preceding 12 month period. Learning points were identified to improve safety in the practice and actions were documented. For example, the practice identified a safety concern following a hospital discharge and took immediate action to contact the hospital and raise it with the service commissioners.

Where an event was caused by the practice's processes, it was discussed and processes amended. For example, where the wrong blood test forms were sent to a patient, an investigation showed that there were errors in read coding and the practice amended its processes to prevent this happening again.

The practice had a process to review and cascade medicines alerts received via the Medicines and Healthcare Regulatory products Agency (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 in support of these roles. For example the children's safeguarding lead was trained to level three in child safeguarding. Quarterly child safeguarding meetings were held between the practice clinicians with the health visitor and school nurse, which were well-documented. On the day of our inspection, the practice met with representatives from Derbyshire Community Health Services (DCHS) to discuss any changes required as part of the new managerial arrangements. This meeting was positive and highlighted potential benefits to the practice such as more readily available expert support and advice from the DCHS safeguarding team. Practice staff demonstrated they understood their responsibilities and had received training relevant to their role.
- A notice in the consulting rooms advised patients a chaperone was available for examinations, if required. Reception and administrative staff would usually act as a chaperone, and they had undertaken some on-line training to support this. However, some staff were not clear about their responsibilities, including where to stand when acting as a chaperone. The practice policy indicated that training would be undertaken annually, although this had not been achieved for all staff due to the pressures involved with the recent integration process with DCHS. The practice were exploring options for further face to face externally-facilitated training. The practice chaperone policy required an update to reflect that the chaperone was able to observe the procedure being undertaken by the clinician. All 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).

Requires improvement

Are services safe?

- We observed that the practice was tidy and maintained to good standards of cleanliness and hygiene. A practice nurse acted as the infection control clinical lead role. There was an infection control policy in place which had recently been updated and staff had received up to date training. Annual infection control audits were undertaken, most recently in April 2016, and we saw evidence that action was taken to address any improvements identified as a result. For example; fabric screens had been replaced with disposable paper ones and clinical areas had been de-cluttered. The practice contracted cleaning services to an external provider. The practice manager liaised with the cleaning contractor on a regular basis and systems were in place to quickly rectify any issues that arose. However, we did not find any evidence of room specific cleaning schedules to monitor that cleaning had been undertaken to the required specification. This included the patient toilet.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Blank prescriptions were securely stored and there were systems in place to monitor their use. 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 recruitment checks had been undertaken prior to employment. For example, proof of identity, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

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 some risk assessments in place to monitor safety of the premises such as manual handling although the practice acknowledged that further work was required in this area. DCHS had recently conducted a fire risk assessment, and the practice carried out annual fire drills. Fire training had been organised to take place on site in July 2016; most staff had completed some fire training on-line. We saw evidence that all electrical equipment had been checked to ensure it was safe to use (most recently in May 2015) and clinical equipment had been checked to ensure it was working properly (last done in October 2015). The practice had recently received a full legionella survey (legionella is a term for a particular bacterium which can contaminate water systems in buildings), and this had identified significant work to be undertaken at the premises. At the time of the inspection, a plan was being developed to organise the necessary work to be carried out with minimal disruption to patient services. The practice told us they would then implement ongoing monitoring arrangements to keep patients and staff safe.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. However, the limited staffing establishment created some concerns with regards to continuity of service. There was only one practice nurse, although a regular bank nurse provided two sessions per week and cover during periods of leave. However, this bank nurse was due to retire imminently. DCHS were aware of this issue and had started to recruit a small number of bank practice nurses who would be available to provide cover for absences. If the health care assistant was off work, the practice nurse would cover any urgent duties. Reception and administrative staff told us that they had been stretched in covering vacancies, although the team were committed to work together to deliver the service effectively. The recent appointment of an apprentice had been extremely helpful in supporting the team's work. The practice told us that GP capacity would be improved by the recruitment of a further part-time GP in June 2016.

Arrangements to deal with emergencies and major incidents

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

· 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.

· Most staff had received annual basic life support training. The practice was aware that staff training required updating and was planning to address this via the new arrangements in place with DCHS.

Requires improvement

Are services safe?

· 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, except for one oral medicine in a GP bag. The GP was aware of this and had planned to remove it. This was remedied immediately by the practice.

· The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan had been updated in April 2016 to reflect the new managerial arrangements. The practice had developed a poster of contact numbers for key services including electricity and water in case of disruption to supplies, which was clearly displayed and accessible to staff. We were informed of an incident involving a breakdown of the practice computer server and how the business continuity plan was put into operation. This was managed with minimal disruption to patient services, and the practice collaborated with another local practice for support throughout this incident.

Good

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. The practice had systems in place to keep all clinical staff up to date when new guidance was received or updated, including a monthly clinical staff meeting. Minutes were recorded to ensure any clinician that had been unable to attend the meeting had access to the information.

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 showed the practice had achieved 99.5% of the total number of points available (compared to the clinical commissioning group (CCG) average of 97% and the national average of 94.7%). The practice had an exception reporting rate of 9%, 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.

Individual exception reporting rates were higher for some indicators including those within the diabetes domain. We saw that the practice sent three reminder letters to patients who failed to attend for appointments but had not followed these up with a telephone call to establish why patients had not attended or check whether their health had deteriorated. The practice were planning to make changes to their management of chronic conditions once they had recruited an advanced nurse practitioner.

We reviewed practice provided data for 2015-16 (yet to be externally published and verified) and this demonstrated that the levels of exception reporting had decreased and were now more in line with expected averages (for example, the exception reporting rate for heart disease had decreased from 14.6% to 9.4% over a two year period).

QOF data from 2014-15 showed:

- Prevalence rates for many long-term conditions were marginally higher than local and national averages. This was related to the higher number of older patients registered at the practice.
- Performance for diabetes related indicators at 99.2% was above the local and national averages of 96.7% and 89.2% respectively. Exception reporting was slightly above averages in six of the ten relevant indicators. This included the measure of total cholesterol at 5mmol/l or less within the preceding 12 months. The practice exception reporting rate was recorded as 24% compared to the local average of 16.9%, and national average of 13.5%. We were assured by the practice that national guidelines used in exception reporting were followed, and we saw evidence that letters had been sent to patients who had not attended for their appointment.
- Performance for mental health related indicators was higher than local and national averages at 100% (96.9%% and 92.8% respectively). Exception reporting levels for these indicators were all below the local and national averages.

There was evidence of quality improvement including clinical audit.

- There had been seven clinical audits undertaken in the last 12 months, one of these was a completed full two-cycle clinical audit where changes were implemented and monitored. For example, an audit was conducted to identify whether best practice was being followed in fitting ring pessaries following a patient event. The first cycle identified areas for improvement to the process for stock control and checks to ensure that pessaries were in date and fit for use. Measures were put in place to ensure that pessaries were checked prior to insertion and to manage stock control and the second audit showed that new processes were being adhered to.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was cost effective, and adhered to local guidance

Good

Are services effective?

(for example, treatment is effective)

- The practice participated in local benchmarking activities. For example, the practice undertook a quarterly review of data provided by their CCG including referral rates and hospital admissions.

Effective staffing

- The practice had a generic induction programme for all newly appointed staff. We saw examples of completed inductions but this did not include any reference to information relating to key issues such as fire and safeguarding. This issue would be addressed to some extent by the new arrangements with DCHS as the new provider, who offered a full induction programme to new starters over three days. We saw evidence that the practice had previously undertaken a robust approach in assessing competencies of new employees although this was less evident for some recently appointed non clinical staff
- 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.
- There was a commitment to staff development and a review of staffing requirements. For example, practice nurses attended external training events, in-house development sessions and mentorship from a specialist diabetes nurse. There were plans to recruit an advanced nurse practitioner to assist with chronic disease management and minor illness sessions.
- Staff had access to on-line training to meet their learning needs and to cover the scope of their work. However, we observed that a large amount of training, including some mandatory training, was overdue. The practice was aware of this issue and were working to address this matter.
- Staff had received an appraisal within the last 12 months.
- A monthly protected learning time event provided opportunities for all staff, including time to undertake their on-line training. GPs often utilised this time to attend events organised by their CCG.

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 district nurses, a social care representative, the care co-ordinator, a physiotherapist and an occupational therapist. A named lead GP attended this meeting for continuity, and meetings were comprehensively documented.
- Quarterly supportive care meetings were held between the practice team and 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 deaths to consider any learning points.
- The practice worked with the CCG's medicines management team who supported the practice. All practice clinicians met with the medicine management team on a quarterly basis.

Consent to care and treatment

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.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Staff were able to articulate how this applied in individual cases, and the actions they would take to adhere to the guidance correctly.
- 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.

Good

Are services effective?

(for example, treatment is effective)

- Consent forms were completed for any invasive procedures including coil fittings and minor surgical procedures. Nurses used a checklist within the patient's notes to record consent for vaccinations and immunisation.

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 wellbeing worker was available at the practice each week to provide advice on healthier lifestyles, and was able to signpost patients into ongoing community based support programmes including services to help patients stop smoking, diet advice, alcohol consumption, and social issues including debt management and isolation.

The practice's uptake for the cervical screening programme was 83.9%, which was above the CCG average of 77.7% and the national average of 74.3%.There was a policy to offer written reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening and uptake was in line with local and national averages. For example; uptake for breast screening in the preceding three years was 78% which was slightly higher than the CCG average of 76% and the national average of 72%. Uptake for bowel screening was 60% which was comparable with the CCG average of 61% and the national average of 58%.

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 93.3% to 100% (local average 93.7% to 97.7%) and five year olds from 98.5% to 100% (local average 91% to 97.6%).

The practice provided health checks for new patients and NHS health checks for patients aged 40–74. A total of 47.3% 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.

Good

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.

- 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 or area to discuss their needs.

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

- 92% of patients said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 82% of patients said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86%, and the national average of 85%.
- 89% 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 92% and national average of 91%.
- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Care home staff informed us that they had a named GP for continuity. They said that residents were treated as individuals and their needs were accounted for. For example, the GP was involved in keeping patients' care plans updated and involved care home staff and patients' families in decisions where that person was not able to make an informed decision for themselves. All the community based staff we spoke with stated that the GPs were approachable, accessible and respectful of their opinions.

The GPs and managers cared for their employees and some staff gave examples of how they had been supported during difficult personal circumstances.

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 generally above, or 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:

- 96% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 88% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%.

Patient and carer support to cope emotionally with care and treatment

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, and those at risk of developing a long-term condition.

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

The practice manager was the appointed practice 'Carers' Champion' to develop the identification and support of carers and had identified 2.6% of the practice list as carers. The practice's computer system alerted GPs if a patient was also a carer. Written information was available to direct carers to the support services available to them. The

Good

Are services caring?

practice hosted monthly carers' clinics which were provided by Derbyshire Carers Association. These were 60 minute appointments where carers could receive practical help and advice about a range of non-medical issues.

The practice worked to provide 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. The practice reviewed patient deaths to ensure that optimal care had been delivered and to consider any learning. However, the practice team did not proactively contact relatives following bereavement. We were informed that support was offered, including signposting to appropriate services such as counselling, if this was requested.

Good

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.
- The practice reviewed arrangements to meet new demands. For example, they were recruiting a salaried GP and an advanced nurse practitioner. Following their integration with DCHS, they were actively involved in discussions regarding additional recruitment to address staffing capacity, and to review additional services that could be hosted on site to benefit patients.
- The waiting area contained a wide range of information on services and support groups.
- A touchscreen check-in facility was available in the waiting area.
- The layout of reception helped to maintain patient confidentiality. The reception was separated from the main waiting area by a door. A separate room was usually available for private and sensitive discussions. This would usually be a free consulting room.
- A community pharmacist held a weekly anticoagulation clinic on site. The pharmacist reviewed, monitored and prescribed for patients.
- Both a counsellor and a cognitive behavioural therapist attended the practice each week on different days to provide support for patients experiencing mental health or emotional difficulties. Cognitive Behavioural Therapy (CBT) is a talking therapy to help manage difficulties by changing the way a person thinks and behaves. Patients could self-refer to this service or be referred directly by the GP.
- The health visitor provided a child health clinic at the practice on a fortnightly basis.
- The practice hosted a monthly consultant psychiatrist clinic which was also open to patients registered with other local GP practices. This meant that patient could be seen in a familiar local environment, avoiding a journey to the hospital.
- A representative from the Citizens Advice Bureau attended weekly to provide advice on benefits.
- A physiotherapist employed by DCHS was to commence an in-house muscular-skeletal service from June 2016.
- The practice was also planning to provide other services from their site and future aspirations included an in-house community psychiatric nurse; a pharmacist to provide medicines reviews and advice to patients; and an advanced clinical practitioner who would work with local care homes and see patients attending the practice with a minor illness. It was hoped that the introduction of the advanced clinical practitioner role would release some additional GP capacity to allow the re-introduction of some bookable GP appointments in the mornings.
- A well-being worker attended the practice each week to provide healthy lifestyle advice and to signpost patients to local support services such as smoking cessation.
- The practice funded equipment that enabled patients to monitor their own height, weight, pulse and blood pressure and to calculate their BMI. A printout could then be handed in to the receptionist to be assessed by a clinician and any concerns could be followed up. The equipment was easily accessible in the waiting area and patients with a chronic condition were encouraged to use it regularly as part of their monitoring.
- 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 every morning via a sit and wait system.
- Long-term condition reviews were co-ordinated to ensure that patients with more than one condition could be reviewed as part of one appointment.
- The practice provided care for 13 residents in a local care and residential home. We spoke to staff 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 that patients were kept under regular review.

- The premises provided good accessibility for patients in wheelchairs, or those with limited mobility. Services were provided on the ground floor, and there were automatic entrance doors. A disabled toilet was available for patients and a hearing loop and available for patients who had hearing difficulties. The practice provided two higher chairs for patients who had difficulty in standing from a low seat.
- Translation services were available for patients whose first language was not English.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was open 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 10.30am every morning on a 'sit and wait' basis. Morning GP surgeries ran until approximately 11.30am in order to see all those patients who had arrived at the practice before 10.30am. Bookable afternoon GP appointments were available between 3pm and 5.30pm. The pre-bookable afternoon GP appointments could be booked two weeks in advance, although the appointments were only released one day at a time. Therefore, on the day of our inspection, we saw that the next available routine GP appointment was available in 2 weeks' time and only available for the one afternoon. Urgent appointments were available for people who needed them and the reception team would identify any patients with high-priority needs to be seen urgently within the sit and wait clinic. Patients could book up to 12 weeks in advance for the practice nurse.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mostly comparable overall to local and national averages, with the exception of consulting with a preferred GP.

- 82% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and national average of 73%.
- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- However, only 16% of patients said they usually got to see or speak to their preferred GP compared to a CCG average of 55% and a national average of 59%. Patients had to book two weeks in advance in order to book an appointment with a preferred GP.

The practice has introduced 'sit and wait' appointments for all GP consultations in April 2015 in order to accommodate patient demand. This was reviewed by a patient participation group (PPG) survey in August 2015 which highlighted that many patients still preferred bookable appointments. This led to a change and the introduction of the current system with the daily mix of 'sit and wait' and bookable appointments in September 2015. The practice were continuing to monitor patient feedback via their Friends and Family Test returns, but had decided not to undertake a further survey at this stage due to limited GP capacity to support any modifications of their appointment system. The PPG had designed a patient letter which was left on each seat in the waiting area to explain the 'sit and wait' system to patients, and also to educate them in when to appropriately come to the practice and advise on other services available to them. Some patients we spoke with on the day said that this system worked well for them whilst others said that they did not like having to wait so long to be seen.

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 in the practice.
- We saw that no information was available to help patients understand the complaints system in the waiting area. The practice told us they would rectify this immediately. Information regarding how to complain was available on the practice website and patients we spoke with on the day told us that they would approach a receptionist if they wanted to make a complaint.

We looked at thirteen complaints received in the last 12 months and 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, further to a complaint, the practice had reviewed their processes for repeat prescriptions and reinforced procedures with the practice team at a staff meeting.

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 recently adopted the values of Derbyshire Community health Services (DCHS) as the new service provider from April 2016.

- The practice team had developed pledges for both the practice and the team at an away day in February 2016. The whole practice team had contributed and agreed to these pledges. The practice pledge focussed upon honesty, dignity and respect for patients, whilst the team pledge highlighted on mutual support and respect between staff.
- Prior to their integration with the community trust; the GPs in the practice held regular business meetings. Since the introduction of new management structures the lead GP was planning to meet with the trust's clinical director on a regular basis.
- The practice did not have a written strategy, although this was apparent in the recent DCHS merger. From April 2016, the practice would form part of the wider DCHS strategy and business planning arrangements.
- We spoke with representatives from the trust who told us that they wanted the practice to maintain their identity and were keen for them to remain involved in local meetings and events with their colleagues across local GP practices. For example, the lead GP and practice manager attended the monthly Clinical Commissioning Group locality meeting.

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. Representatives from DCHS explained how the practice fitted into the Trust's governance structure with clear line management and professional accountability.
- Practice specific policies were implemented and were available to all staff electronically. There was an ongoing period of transition as the practice amended its policies to be in accordance with Trust governance arrangements.
- The practice engaged with their CCG, and the practice attended locality meetings and the practice managers' forum to work collaboratively and share best practice.
- Arrangements were evolving for identifying, recording and managing risks, but were not yet sufficiently robust for the provider to be assured that all mitigating actions were effective

Leadership and culture

The new provider demonstrated they had the experience, capacity and capability to run the practice effectively and ensure high quality care. They told us they prioritised safe, high quality and compassionate care.

There was a clear leadership structure in place and staff felt supported by management.

- The new provider arrangements under DCHS offered significant benefits to the practice in terms of additional support to many administrative functions. For example, the Trust's Human Resources department would be able to manage and co-ordinate staff recruitment processes. Staff told us the practice held monthly full practice team meetings. These meetings were documented so they could be made available to any staff who could not attend. Minutes from these meetings were e-mailed to the practice team and a hard copy was also kept on file.
- 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.
- A team away day had been held in February 2016 to discuss the changes in management with DCHS from April 2016. This included input from the DCHS staff support service, in recognition of the management changes and the potential anxieties this created for staff.
- Occasional social events throughout the year, including a recent retirement party for a GP, helped create a strong and supportive team spirit within the practice.
- Staff said they felt respected, valued and supported, by the GPs and managers in 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 sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Good

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

- The practice had gathered feedback from patients through the patient participation group (PPG); through patient surveys; via complaints received; from feedback received on the NHS Choices website; and responses received as part of the Families and Friends Test (a simple feedback card introduced in 2013 to assess how satisfied patients are with the care they received).
- We saw evidence that the practice had organised their own patient surveys to assess satisfaction and took action to address any issues raised.The PPG has a core membership of 5 and not 15, it meets on a monthly basis and not quarterly. The practice does not have a virtual network.
- The PPG met on a monthly basis, and had a core membership of around five patients. The PPG had been instrumental in influencing developments at the practice. For example, in reviewing the appointments system.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.