Dr M A Bradley

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr M A Bradley (Newbold Surgery) on 12 August 2016. Overall the practice is rated as good.

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

- There was an effective system in place for the reporting and recording of significant events. Learning was applied from events to enhance the delivery of safe care to patients.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- A programme of clinical audit reviewed care and ensured actions were implemented to enhance outcomes for patients.
- The practice worked with members of the wider health and social care team to keep vulnerable patients safe. However, they did not participate in regular multi-disciplinary team meetings to plan and co-ordinate patient care collaboratively.
- The practice had an effective appraisal system in place and was committed to staff training and development. The practice team had the skills, knowledge and experience to deliver high quality care and treatment.
- Patients told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients provided positive views on their experience in making an appointment to see a GP or nurse. The practice offered a range of appointment options including pre-bookable routine, urgent, and telephone consultations each day. Longer appointments were available for those patients with more complex needs.
- The practice had good facilities and was well-equipped to treat patients and meet their needs. Some adjustments had been made within the premises to ensure these were easily accessed by patients with a disability.
- There was a clear leadership structure in place and the practice had a governance framework which supported the delivery of good quality care. Regular practice meetings occurred, and staff said that GPs and managers were approachable and always had time to talk with them.

Summary of findings

- The partnership had a clear vision for the future of the service, and were proactively engaged with their CCG in order to progress this.
- The practice had an open and transparent approach when dealing with complaints. Information about how to complain was available, and improvements were made to the quality of care as a result of any complaints received.
- The practice analysed and acted on feedback received from patients in conjunction with their patient participation group (PPG). There was clear evidence that the practice aimed to address patient feedback and continually improve their service provision.

The areas where the provider should make improvement are:

- Review the monitoring arrangements for the distribution of blank prescriptions within the practice.
- Review practice staff attendance at the fortnightly multi-disciplinary team meetings with community health and social care staff.
- Review the availability of clinical meeting minutes for all clinicians within the practice.
- Continue to increase the uptake of annual health reviews for patients with a learning disability, and strengthen the use of coding in this group to ensure the register is correct.

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?

Good

- Staff were supported to report significant events in a supportive environment. Learning was applied from incidents to improve safety in the practice.
- The practice had robust systems in place to ensure they safeguarded vulnerable children and adults from abuse. We saw evidence that the practice had worked closely with local care homes to increase the understanding of their patients' needs to help safeguard vulnerable older adults.
- The practice worked to written recruitment procedures to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- There were systems in place to identify and control risks to patients and the public. For example, the practice had a designated infection control lead who undertook regular audits and took action to address any issues that were identified.
- The practice required a more robust approach to the tracking of blank prescriptions distributed within the practice.
- Patients on high-risk medicines were monitored on a regular basis, and there were processes in place to follow up any patients who had not collected their prescriptions. Actions were taken to review any medicines alerts received by the practice, to ensure patients were kept safe.
- The practice had systems in place to deal with medical emergencies.
- The practice ensured staffing levels were sufficient at all times to meet their patients' needs.
- The practice had developed contingency planning arrangements, supported by a comprehensive and up to date written plan, which was regularly updated.

Are services effective?

Good

- 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.
- The practice had acquired a total achievement of 99.5% for the Quality and Outcomes Framework (QOF) 2014-15. This was slightly higher than the CCG average of 98.1%, and the national average of 94.7%.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment. New employees received comprehensive inductions, and all members of the practice team had received an appraisal in the last year, which included a review of their training needs.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs, in order to deliver care effectively. However, the practice did not attend regular meetings with the wider health care team to discuss their most vulnerable patients.
- A daily informal clinical meeting was held to address any problems that had emerged during the morning. This helped to get issues resolved quickly and also provided a valuable source of support for clinicians.
- The practice received regular input from an independent pharmacist and a CCG medicines management technician that provided robust support on prescribing issues.
- We saw examples of how clinical audit was being used to improve quality and enhance safe patient care and treatment. There was scope to review the audit programme with a focus on topics with potentially greater impact, or to assess compliance with new or revised guidance.

Are services caring?

Good

- We observed a patient-centred culture and approach within the practice. Staff treated patients respectfully and with kindness.
- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated they felt treated with compassion and dignity, and were given enough time during consultations. Patients told us they were involved in decisions about their care and treatment.
- Data from the latest GP survey showed that patients generally rated the practice in line with local and national averages in respect of care.
- Feedback from community based health care staff and care home staff was positive about the high standards of care provided by the practice team.
- The practice had identified 2.2% of their list as being carers, which was in line with expected averages. Information was available on the various types of support available to carers. The practice were considering how to develop the support they provided to carers to a greater extent.
- Most GPs held a personal patient list to ensure continuity of care for patients.

Summary of findings

Are services responsive to people's needs?

Good

- Comment cards and patients we spoke with during the inspection provided generally positive experiences about obtaining a routine appointment with a GP, or being able to speak to someone regarding their concerns. The latest GP survey showed that patient satisfaction was generally in line with local and national averages with regards access to GP appointments.
- There was in-built flexibility within the appointment system including pre-bookable slots; telephone consultations; and 'on the day' urgent appointments.
- The practice offered an extended hours' surgery on two evenings each week.
- Patients could book appointments and order repeat prescriptions on line. The practice participated in the electronic prescribing scheme, so that patients could collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- The practice hosted some services on site including physiotherapy and a weekly Citizens Advice Bureau session. This made it easier for their patients to access services locally.
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The premises were tidy and clean and well-equipped to treat patients and meet their needs. The practice accommodated the needs of patients with disabilities, including access to the building through automatic doors.
- The practice reviewed all concerns and complaints received promptly, and dealt with these in a sensitive manner. Information about how to complain was available for patients. Learning from complaints was used to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they could be offered a more private area to ensure their privacy.

Are services well-led?

Good

- The partners had a commitment to delivering high quality care and promoting good outcomes for their patients. This was reflected within the practice's mission statement and underpinned service aims and objectives.

Summary of findings

- The partners and practice manager valued and appreciated their team and we were given examples of how they had supported individuals. They held an ethos that staff needed care to deliver the best care for their patients.
- There was a clear staffing structure in place. GPs and nurses had lead roles providing a source of support and expert advice for their colleagues
- The partners worked collaboratively with other GP practices in their locality, and with their CCG. They were proactively engaged with the CCG's strategy to deliver care closer to people's homes.
- The partners reviewed comparative data provided by their CCG and ensured actions were implemented to address any areas of outlying performance.
- Staff felt well supported by management, and the practice held regular staff meetings.
- The practice had developed a wide range of policies and procedures to govern activity.
- The practice sought feedback from patients, which it acted on to improve service delivery.
- The practice had a proactive Patient Participation Group (PPG). This group worked well with the practice, and made suggestions to improve services for patients. We saw that a number of projects had been initiated or supported by the PPG.
- High standards were promoted and owned by all practice staff who worked together effectively across all roles.

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

- Although the practice worked collaboratively with the wider health and social community to plan and co-ordinate care to meet their patients' needs, they did not participate in regular meetings on site attended by the wider multi-disciplinary team. However, there was good liaison in place between the care co-ordinator and practice clinicians to ensure effective and co-ordinated patient care.
- Longer appointment times could be arranged for those patients with complex care needs, and home visits were available for those unable to attend the surgery.
- The practice provided care for residents at two local care homes, and fortnightly visits were undertaken to each home by a GP. The same GP usually visited each home to ensure continuity of care, and build good relationships with the care home team. Care plans were in place to support the ongoing needs of these patients.
- The practice worked with an independent pharmacist and the CCG medicines management technician to review the long-term use of multiple prescribed medicines, including those patients that were housebound.
- Uptake of the flu vaccination for patients aged over 65 was 78%, which was higher than local (73.9%) and national (70.5%) averages. An annual flu clinic had developed into a local social community event with representatives from organisations including the fire brigade, the Alzheimers Society, and carer support charities. The Patient Participation Group (PPG) helped to organise and co-ordinate the event which took place in the local village hall.

People with long term conditions

Good

- The practice undertook annual reviews for patients on their long-term conditions registers. The recall system was co-ordinated by a dedicated member of staff. Housebound patients would be visited by the health care assistant to undertake screening tests which would then be reviewed by a GP.
- Patients with multiple conditions were usually reviewed in one appointment to avoid them having to make several visits to the practice.

Summary of findings

- There was a lead designated GP and/or nurse for all the clinical domains within QOF.
- The practice had upskilled their nursing team to deliver effective care for patients with long-term conditions. For example, three nurses were independent prescribers and had completed additional training in specific disease management areas. This included a nurse who was being supported to do accredited training in spirometry.
- A specialist diabetes nurse attended the practice to undertake a joint monthly clinic with the practice nurse to manage more complex patients with diabetes. This included those with a learning disability or poor mental health. The specialist nurse had provided insulin initiation training to develop the expertise of the practice nurse in the management of diabetes.
- There was an emphasis towards self-management, and care plans were developed with patients to set their own goals.
- Patients with a long-term condition received a written invitation to attend the surgery for a pre-booked appointment to receive their annual flu vaccination.

Families, children and young people

Good

- The GPs saw new mothers for a post-natal review and baby check. This was used an opportunity to book the infant's vaccination appointments.
- Childhood immunisation rates were in line with local averages. Rates for the vaccinations given to children up to five years of age ranged from 92.9% to 100% (local averages 95.2% to 99.1%).
- The health visitor and midwife attended a meeting with the lead GP for child safeguarding once a month to discuss any concerns. Child protection alerts were used on the clinical system to ensure clinicians were able to actively monitor any concerns.
- Appointments for children were available outside of school hours.
- Family planning services were provided to fit and remove intrauterine devices (coils) and implants, and advice and support was available for all aspects of contraception. This included the c-card scheme (a free condom distribution and advisory service for 13-19 year olds). Chlamydia screening kits were available in patient toilets.
- The practice worked within their local community to promote health – for example, a GP had attended three local schools to

educate children about attending the doctor's surgery without apprehension. As part of this, the practice ran a new practice logo design competition, and displayed this at the practice entrance, and on leaflets and letterheads.
- The practice had baby changing facilities, and welcomed mothers who wished to breastfeed on site. Toys and books were available for small children.

Working age people (including those recently retired and students)

Good

- The practice offered on-line booking for appointments and requests for repeat prescriptions. The practice provided electronic prescribing so that patients on repeat medicines could collect them directly from their preferred pharmacy.
- Extended hours' GP and nurse consultations were available on two evenings each week.
- Telephone consultations were available each day, meaning that patients did not have to travel to the practice unnecessarily.
- The practice promoted health screening programmes to keep patients safe. NHS health checks were available towards the end of the day to enable working people to attend more easily.
- Pre-bookable evening appointments were provided for flu vaccinations for patients aged 18-65.

People whose circumstances may make them vulnerable

Good

- The practice was working hard to increase the uptake of annual health checks of patients with a learning disability, and had introduced easy-read letters with picture prompts, and liaised with carers to co-ordinate attendance. However, not not all patients were correctly coded on the practice's IT system. Information received following the inspection confirmed that 71% of eligible patients had received a health check in the last 12 months. The coding of patients had also been updated to ensure the register was correct.
- A GP worked with the local substance misuse service to provide a shared care drug clinic on site. This service had recently been extended to other patients registered with a different practice but residing locally.
- There was a designated lead GP for palliative care. Patients with end-of-life care needs were reviewed at designated monthly palliative care meetings. However, the minutes of these meetings were not readily available to other practice clinicians. All patients nearing their end of life had appropriate care plans in place to meet their needs.

Summary of findings

- The practice supported homeless patients to register at the practice.
- Staff had received adult safeguarding training and were aware how to report any concerns relating to vulnerable patients. There was a designated lead GP for adult safeguarding, who had delivered some safeguarding training to support staff at a local care home.
- The practice worked with patients to promote mutually respectful relationships with clear boundaries. This helped to provide help and support to some patients, enabling them to stay registered with the practice, rather than removing them from their list and passing difficulties onto another practice.
- The practice was a recognised safe haven for people with a learning disability. This Derbyshire partnership scheme aimed to protect people with learning disabilities from potential bullying or abuse, and helped them feel safe and confident within the community by having access to a place where they could be supported if required.
- Longer appointments and home visits were available for vulnerable patients.

People experiencing poor mental health (including people with dementia)

Good

- The practice achieved 100% for mental health related indicators in QOF, which was 1.9% above the CCG and 7.2% above the national averages. Exception reporting rates for mental health were higher at 20.3% (local 14.5%; national 11.1%).
- 96.9% of patients with poor mental health had a documented care plan during 2014-15. This was slightly above the CCG average of 93.2% and higher than the national average of 88.5%.
- Key information from annual reviews was shared with secondary care to ensure that physical health was maintained for these patients.
- In-house access to counselling and associated talking therapies was available by GP or self-referral.
- The practice had established good working relationships with local community mental health care teams and the community psychiatric nurse (CPN).
- 80.6% of people diagnosed with dementia had had their care reviewed in a face-to-face meeting in the last 12 months. This was slightly below local and national averages by approximately 3.5%. Exception reporting rates were higher at 14.3%, compared to the local and national average of 8.3%.

Summary of findings

- The practice staff had received training to become 'Dementia Friends' and were working to achieve full dementia friendly practice status. The PPG had been involved in this process and had reviewed internal signage to meet the needs of patients with dementia. This included using numbers on consulting room doors and the use of black signs on a yellow background as these are easier for older people to see, especially those with dementia.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016, and the results showed the practice was generally performing in line with local and national averages. A total of 220 survey forms were distributed and 124 of these were returned, which was a 56% completion rate of those invited to participate.

- 82% of patients found the receptionists at this surgery helpful compared against a CCG average of 89% and a national average of 87%.
- 73% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 71% and a national average of 65%.
- 88% of patients said they would recommend this surgery to someone new to the area compared to a CCG average of 84% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards which were all extremely positive in respect of the level of care provided and the interactions with the whole practice team. Patients said they were treated in a caring and respectful manner by staff. They also said they were given sufficient time and were listened to during their consultations. There were no adverse comments in relation to obtaining an appointment to see a GP.

All of the 14 patients we spoke with during the inspection said that they were treated with dignity and respect by the practice staff. Patients reported a high level of satisfaction regarding their consultations, stating that they were provided with sufficient consultation time and that they felt treated as individuals.

Dr M A Bradley

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 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 Dr M A Bradley

Dr M A Bradley (also known as Newbold Surgery) provides care to approximately 11,308 patients in the village of Newbold, to the north of Chesterfield. The practice provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The site operates from a purpose built two-storey detached building constructed in 1987, and all patient services are provided on the ground floor.

The practice is run by a partnership of five GPs (four male and one female) and the partners employ four female salaried GPs. Newbold Surgery is an established training practice with two GP registrars in place at the time of our inspection.

The nursing team is led by a senior practice nurse acting as the nurse manager with a team of four more practice nurses and four health care assistants. The clinical team is supported by a practice manager and a patient services manager, with a team of 16 administrative and reception staff. The practice also employs three cleaning staff.

The registered patient population are predominantly of white British background with higher percentages of patients aged over 50. The practice is ranked in the fifth more deprived decile with a deprivation score (2015) of 24.4 compared against a CCG average of 18. Although the practice serves a predominantly urban area, the practice boundary extends to some rural villages on the edge of the Peak District.

The practice opens daily from 8am until 6.30pm. Extended hours opening operates every Tuesday and Wednesday evening when the practice opens until 8pm. The practice closes one Wednesday afternoon each month for staff training.

Scheduled GP morning appointments times are usually available from approximately 8.40am until 10.50am. Afternoon GP surgeries run approximately from 2.30pm to 5pm. Extended hours appointments on Tuesday and Wednesday evenings are available between 6.30pm and 7.20pm

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

Why we carried out this inspection

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

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

Detailed findings

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

How we carried out this inspection

Before our inspection, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England and NHS North Derbyshire CCG to share what they knew.

We carried out an announced inspection on 12 August 2016 and during our inspection:

- We spoke with staff including GPs, the practice manager, the patient services manager, and members of the nursing team and reception and administrative staff. In addition, we spoke with representatives from two local care homes, the district nursing team lead, and a care co-ordinator regarding their experience of working with the practice team. We also spoke with 13 patients who used the service, and the secretary of the practice's 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 37 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)

Good

Are services safe?

Our findings

Safe track record and learning

There was a procedure in place for reporting and recording significant events, and the practice encouraged staff to report incidents within a supportive 'no blame' culture.

- A significant event reporting form was available to all staff electronically, and a separate form was used to analyse the incident and record outcomes.
- The practice discussed incidents at either clinical or general staff meetings. These were held monthly, and those with wider learning were shared across all staff groups. Significant events were a standing item on the monthly staff meeting agenda. We saw that notes were recorded from the event meetings and these provided evidenced that learning had been applied.
- We saw examples of learning that had been applied following events. For example, a patient had experienced a delay in receiving a clinical procedure. This happened when a GP registrar sent an in-house referral to the wrong clinician. The GP registrar then left the practice and so did not see a task that had been sent back advising this, creating a delay for the patient. The practice team reviewed the incident and took action to ensure that in-house procedures were included and signed off as part of the GP registrar induction programme. Additionally, staff were tasked to monitor leavers more closely and remove them from the system immediately to prevent any future recurrence, and copies of procedures were placed in a central location for ease of reference.
- An annual review of events took place. This provided an opportunity to review any trends, and to ensure that all follow up actions had been completed.
- Some complaints were reviewed via the incident reporting process to consider any learning that may apply. Patients were informed about this and were given the opportunity to decline involvement in the process.
- People received support and an apology when there had been unintended or unexpected safety incidents.

The practice had a process to review alerts received including those from the Medicines Health and Regulatory Authority (MHRA). This was supported by a written protocol. When concerns were raised about specific medicines, patient searches were undertaken to identify which patients may be affected. Effective action was then taken by clinicians to ensure patients were safe, for example, by reviewing their prescribed medicines.

The practice manager maintained a comprehensive record of all the alerts received by the practice including the actions taken. This provided an excellent source of evidence of compliance in this area, and was a useful reference document for staff.

Overview of safety systems and processes

The practice had defined systems and procedures 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 guidance and policies were accessible to staff. Practice safeguarding policies were accessible and up-to-date, and alerts were used on the patient record to identify vulnerable children and adults. There were designated lead GPs for safeguarding both children and adults, who had received training at the appropriate level in support of the role. The health visitor, school nurse and midwife attended a monthly meeting with the lead GP to discuss any child safeguarding concerns, including pregnant mothers who were considered as being at risk. Any relevant information was added into the patient's electronic record after the meeting and the GP would send an alert to the other clinicians regarding any issues they needed to be aware of. Minutes of the meeting were not available, but the GP took notes which were made available to the team if required. The GP reviewed information relating to any child protection case conferences and provided information as and when required. Safeguarding was a standing agenda item at monthly staff meetings, providing a further opportunity to raise awareness of any safeguarding matters. If a child at risk of harm moved to another GP practice, the practice would send a notification to ensure they were aware of this. Practice staff demonstrated they understood their responsibilities and all had received training relevant to their role. The lead GP was able to provide an example of where action had been instigated to protect a child's welfare.

Good

Are services safe?

The adult safeguarding lead GP had worked closely with staff in a local care home to enhance their understanding of safeguarding vulnerable adults within their daily work.

- A notice in the reception and the consulting rooms advised patients that a chaperone was available for examinations upon request. Members of the reception team had undertaken training in support of this role and would act as a chaperone if a nurse or health care assistant were not available. Staff who undertook chaperoning duties 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). A practice chaperone policy was available.
- We observed that the practice was tidy and maintained to good standards of cleanliness and hygiene. The nurse manager was the appointed infection control lead, who had undertaken training in support of the role. There were infection control policies in place, which had been reviewed regularly. Practice staff had received infection control training and received information as part of new staff inductions. A comprehensive infection control audit had been completed in December 2015, and we saw evidence that actions had been undertaken in response to the findings. Spot checks to assess cleaning standards were performed between annual audits by the infection control lead and the practice manager, and action was taken to address any issues that were identified. For example, when issues were identified, a meeting took place with the cleaners to reinforce the standards required. The practice employed three cleaners and comprehensive written schedules of cleaning tasks were available. Documentation was available to support the control of substances hazardous to health including any spillages.
- We reviewed three staff files and found that the necessary recruitment checks had been undertaken prior to commencing work with the practice. For example, proof of identification, qualifications, registration with the relevant professional body and the appropriate checks through the DBS.
- The practice had a robust system to manage incoming correspondence to ensure that any actions, such as a change to a patient's medicines, were completed promptly. We saw that correspondence was up to date on the day of our inspection.

Medicines management

- The arrangements for managing medicines in the practice, including emergency medicines and vaccinations, kept patients safe. Blank prescription forms and pads were securely stored although systems lacked robustness to monitor their distribution throughout the practice. Regular medicines stock checks including expiry dates were undertaken. Signed and up-to-date Patient Group Directions were in place to allow nurses to administer medicines in line with legislation, and healthcare assistants administered medicines against a patient specific prescription or direction from a prescriber.
- There was a robust process and written policy in place in support of repeat prescriptions. Systems were in place to monitor patients prescribed high-risk medicines, which was recorded on a spreadsheet with a monthly review undertaken. Monitoring included a nurse-led clinic for patients prescribed disease modifying anti-rheumatic drugs (DMARDs) by a hospital consultant.
- Uncollected prescriptions were shredded after six months, but there were procedures to monitor them and the GPs were informed with regards any medicines compliance concerns.

Monitoring risks to patients and staff

- A practice health and safety policy was available.
- The practice manager had completed a range of risk assessments to proactively manage any new or emerging risk areas. This included lone working for staff undertaking home visits, and for the member of staff on reception during the extended hours clinics. Measures had been taken to control the risks, and these were kept under review. Site related issues requiring funding were added onto a rolling maintenance programme.
- A comprehensive external fire risk assessment had been undertaken by a fire safety specialist in April 2016. This had resulted in an action plan and we saw evidence that the practice had responded to all the points that had been identified. Fire alarms and extinguishers were serviced regularly to ensure they were in full working order. The alarm was tested weekly and emergency lighting was checked on a monthly basis, and this was

recorded. Staff had received regular fire training, and the practice undertook trial evacuations every six months to ensure staff were aware of the procedure to follow in the event of a fire.

- All electrical equipment was regularly inspected to ensure it was safe to use, and medical equipment was calibrated and checked to ensure it was working effectively. We saw certification that this had been completed by external contractors in the last 12 months.
- The practice had completed a risk assessment for legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings) which concluded that the risks were insignificant and being managed to comply with the law. The practice intended to review this if building work was instigated in the future as part of a premises development bid.
- There were arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. This included a structured programme for annual leave arrangements, and a minimum staffing quota.

Arrangements to deal with emergencies and major incidents

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

- Staff had received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Whilst a system was in place to ensure that maintenance checks were carried out on this equipment to ensure it was working effectively, records were not available to clearly show this.
- 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.
- Audible alarms were available in the reception and all clinical rooms, and call systems on all computers to alert staff to assist rapidly with any emergency situation, such as if a patient were to collapse.
- The practice had a business continuity plan for major incidents such as power failure or building damage. Copies of the plan were kept off site in case any incidents made entry to the site inaccessible. Buddying arrangements with a local GP practice had been agreed as a contingency to provide some temporary accommodation and access to computer systems. The plan was reviewed regularly with the most recent update in March 2016.

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.

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 were 99.5% of the total number of points available. Exception reporting rates at 12.9% were marginally above local and national averages of 11% and 9.2% respectively. Exception reporting is the removal of patients from QOF calculations where, for example, a patient repeatedly fails to attend for a review appointment.

QOF data from 2014-15 showed:

- Performance for diabetes related indicators was 96.7%, which was the same as the CCG average and above the national average of 89.2%. Exception reporting for these indicators at 14.2% was marginally above the CCG average of 13.4%, and above the national average of 10.8%. The practice were aware that foot assessments for patients with diabetes was any area for improvement and had tried to address this in liaison with the podiatry team, and with the health care assistant undertaking reviews for low risk patients.
- 86.8% of patients with hypertension had regular blood pressure tests, which was in line with the CCG average of 85.3%, and the national average of 83.6%.
- QOF achievement for 2014-15 for asthma was 100% which was marginally above local and national averages. However, exception reporting rates were much higher at 26.5% (local 9.6%; national 6.8%). We discussed this with the practice who were able to explain the efforts they employed to encourage these patients to attend a review appointment. For example the practice sent a minimum of three letters, text message reminders and offered late appointments, and advised patients of the importance of their attendance in writing.
- The practice achieved 100% for indicators related to chronic kidney disease which was 3.5% above the CCG average and 5.3% above the national average. Exception reporting rates were in line with local and national averages.

Practice held data, which has not yet been verified, demonstrated that high QOF achievement had been maintained at 99.5% for 2015-16.

There was evidence of quality improvement including a programme of clinical audit.

We saw evidence of a programme of audit including four clinical audits undertaken in the last year. Three were completed full-cycle audits where changes had been implemented and monitored with positive outcomes for patients. We reviewed a full cycle audit on patients with atrial fibrillation being prescribed anticoagulation medicines where this was indicated, and not being prescribed aspirin without a justified clinical rationale. This showed an increase in appropriate patients who were taking an anticoagulant had risen from 59% to 79%, and a marked decrease in appropriate patients were taking aspirin which reduced from 37% to 12.5%.

- The audit programme was limited in scope with selected topics that did not always have a significant impact upon patient care. We did not see evidence that the practice were using the audits undertaken by their GP registrars to enhance quality care.
- The practice worked with the CCG medicines management pharmacy technician who visited regularly and carried out medicines audits to ensure prescribing was cost effective, and adhered to local guidance. Data demonstrated that the practice's performance for prescribing was good and in alignment with local averages.
- The practice participated in local benchmarking activities. For example, they participated in annual quality focussed visits with the CCG to review comparative data including referral rates and hospital admissions.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

- The practice had established an effective clinical skill mix within their team. For example, the practice employed five practice nurses, three of whom specialised in treating patients with a long-term condition and were able to prescribe specific medicines.
- The practice provided a comprehensive induction programme for all newly appointed staff. We saw this was supported by documentation which included the sign-off of competencies where appropriate. Staff told us they were well-supported when they commenced their roles with shadowing opportunities and had easy access to support from their colleagues. New starters received a three-month review to complete their induction and check that they were adequately prepared to undertake their roles.
- Staff had received an annual appraisal and we saw documentation that evidenced this. We spoke to members of the team who informed us of how learning opportunities had been discussed during the appraisal and supported by the practice. For example, a nurse who specialised in the management of long term conditions was undertaking an accredited course with the Association for Respiratory Technology and Physiology (ARTP) to perform and interpret spirometry (a breathing test) results to nationally recognised high standards.
- The practice ensured role-specific training with updates was undertaken for relevant staff e.g. administering vaccinations and taking samples for the cervical screening programme.
- Staff received mandatory training that included safeguarding, fire safety awareness, and basic life support. Staff had access to and made use of e-learning training modules and in-house training. The practice had protected learning time on one afternoon each month when in-house training was arranged for the practice team. GPs attended training events organised by their CCG on some of these months.
- The nurses who prescribed some medicines were able to access support from GPs in relation to their prescribing role, but did not receive formal mentoring.
- The practice had supported nurses to attend events in support of their revalidation. The nurse manager had undertaken monthly support sessions to help facilitate the successful revalidation of one of the practice nurses.
- The training practice supported GP registrar and medical student placements, and had received good feedback from the doctors who had worked with them. Two nurses were qualified mentors and supported new practice nurses in their role within the practice and externally. The practice had supported the nurses to attend the mentor course at university. The nurse manager was becoming involved in GP registrar training tutorials for long-term conditions, and had also supported three health care assistants to achieve a diploma in primary care and healthcare management.
- An independent pharmacy was located next to the practice. The practice had used some resource released from their prescribing budget to fund the pharmacist to work within the practice. This included input into reviewing medicine compliance issues, reviewing hospital discharges in terms of prescribed medicines, and general prescribing guidance and support for clinicians.

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.
- Fortnightly multi-disciplinary meetings were held at the practice to assess the range and complexity of patients' needs, and to plan ongoing care and treatment for vulnerable patients including those at high risk of hospital admission. These meetings included the community matron, care co-ordinator, social services, district nurses and others including a community psychiatric nurse, occupational therapist and physiotherapist when relevant patients were reviewed. However, there was no practice representative at these meetings and the minutes were not shared with the practice. We discussed this with the practice and the care co-ordinator who informed us that there was excellent ongoing liaison between the community matron and care co-ordinator with the GPs, aided by them having an office base within the practice. This was enhanced by regular communications and updates sent via the electronic task and notification system. The practice informed us that they would ensure they had access to the minutes from the meeting in the future and these would be made accessible to all clinicians.
- Monthly multi-disciplinary meetings involving a lead GP and a senior district nurse were held to review patients on the practice's palliative care register. A Macmillan nurse and local hospice representative would also

attend the meeting periodically. This ensured patients with end of life needs and their carers received the support they required. The lead GP took notes but these were not easily accessible at the time of the inspection. We were informed these were saved on the GP's computer desktop. However relevant information relating to each patient discussed at the meetings was recorded in the clinical system, which other clinicians had access to. The practice had identified that the centralisation and availability of such documents was an issue prior to our inspection and were taking action to address this. The practice had invested in a new IT document management system which would go live in autumn, and this would create a more robust process to store and access all relevant practice documents.

- Clinical staff met together informally at the end of each morning session, offering an opportunity to share information, and to resolve any issues that had arisen that day. A formal clinical team meeting was held each month during the protected learning time session.

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. They provided an example of how this had been applied as part of the administration of covert medicines for some patients in nursing homes in line with NICE guidance.
- When providing care and treatment for children and young people, staff followed national guidelines to assist clinicians in deciding whether or not to give sexual health advice to young people without parental consent.

Supporting patients to live healthier lives

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

- The practice referred relevant patients for advice on healthier lifestyles, including services to help patients stop smoking, and to control alcohol intake.
- The practice provided new patient health checks, and NHS health checks for patients aged 40-74. In total, 62% of patients that were invited had attended a NHS health check in the last 12 months. Appropriate follow-up on the outcome of any health assessments was taken where abnormalities or risk factors were identified.
- Uptake for the cervical screening programme was 84.8%, which was in line with the local CCG average of 84.1%, and national average of 81.8%. National screening programme data showed the uptake for bowel screening was generally in line with the local average, but higher than national averages.
- Childhood immunisation rates for the vaccinations given to children aged up to five years of age were in line with averages. The overall childhood immunisation rates for the vaccinations given to under two year olds ranged from 96.5% to 100% (local average 95.2% to 98.9%) and five year olds from 92.9% to 99.3% (local average 96.5% to 99.1%).

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations and treatments.

Throughout our inspection, we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect. A caring and patient-centred approach was demonstrated by all staff we spoke with during the inspection.

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 July 2016 showed the practice was in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 94% of patients said the last GP they saw was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 94% of patients said the last GP they saw gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to a CCG average of 90%, and the national average of 85%.

We spoke to some members of the local community health provider team and care home staff who reported that the GPs were patient-centred, approachable and respectful of their opinions.

The partners recognised that they could only achieve their objectives and aspirations with a work-force that were happy and well-supported. There was a strong commitment to staff welfare and we heard examples of this from staff during our inspection. For example, one of the practice team members informed us how they had been supported during an illness, and the care and support that had been offered to facilitate their phased return to duties.

The practice participated in a national project to produce 'twiddlemuffs', a visual and tactile stimulation for patients who benefited from having something to keep their hands occupied (for example, patients with dementia). The practice provided these free-of-charge to any patients who they felt would benefit from their use. The scheme helped foster a community spirit by inviting patients to help produce them, or to provide unwanted supplies of wool.

The PPG and practice team members had supported local charities. For example, the practice manager and patient services manager had raised funds for the local hospice on a sponsored night walk; and the PPG had raised funds by the sale of cakes and drinks during the flu campaign hosted in the village hall.

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.

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

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 86%.
- 97% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and the national average of 90%.
- 95% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87%, and the 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.

Good

Are services caring?

The practice had identified 2.2% of the practice list as carers. They identified new carers upon registration and provided them with an information pack. The practice had previously identified a designated 'Carers' Champion', but this staff member had left the practice, and a new champion had not yet been identified. They had not established any formal links with the local carers association at the time of our inspection. The practice was aware that their approach needed to be more specific to carers' needs and were starting to address this, for example, they would be contacting carers to encourage vaccination against the flu virus. The practice planned to review their approach to provide a more proactive approach with carers in the future. Signposting details for carers were available in the reception area, and the practice website provided links to a range of helpful information for carers.

The practice worked to high quality standards for end of life care to ensure that patient wishes were clear, and that they were involved in the planning of their own care. A representative from the district nursing team told us that the GPs were approachable and responsive to patients' needs including those receiving end of life care. Practice data showed that 74% of patients had died in their preferred place during 2013-14. GPs would usually contact relatives by telephone following a patient death, and would visit them if required. Information was provided to signpost carers to appropriate services such as counselling where indicated. There was poster about bereavement support in the waiting area.

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. For example, the practice wished to improve their premises in order to enhance the environment and to be able to provide more services to their patients. They had submitted a bid to the CCG in support of this proposal.
- A GP worked with the local substance misuse service to provide a shared care drug clinic on site. The GP had completed an additional qualification to support this role. This service had been extended to other patients registered with a different practice but residing locally. Robust information sharing protocols had been developed to ensure safe prescribing for these patients.
- Patients could order repeat prescriptions on line. The practice participated in the electronic prescription service, enabling patients to collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- All of the consulting rooms were accessed on the ground floor. The site was accessible for patients with reduced mobility, and access to a hearing loop system within reception and the consulting rooms was provided for patients with a hearing impairment. The practice had undertaken some site refurbishments to comply with the Equality Act including lowering access to the reception desk for wheelchair users. The practice had their own wheelchair which relatives could borrow to aid access from the car park into the surgery for those patients with impaired mobility.
- The practice provided a range of services that ensured these were easily accessible for their patients. This included 24 hour blood pressure monitoring; spirometry (a test to assess breathing); travel vaccinations; and performed some minor operations (including joint injections and removal of asymptomatic benign skin lesions).
- The practice had recently purchased an ECG machine to test the heart's rhythm. Prior to this, patients had to travel to the local hospital to have this test performed. The practice were undertaking an audit of this service to gauge patient views on how useful this service was for them.
- The waiting area contained a good range of information on local services and support groups. Health promotion material was clearly displayed.
- A touch screen log in facility was available for patients to book in upon arrival at the surgery, which displayed approximate waiting times. A television screen displayed health information and appointments for patients in the waiting area.
- Patients could be moved to a more private area adjacent to the main reception desk for private discussions, or alternatively they could be offered a consulting room if this was available. There was a sign on reception asking patients to stand back whilst other patients were being spoken to, and also highlighted to patients that they could be seen in a more confidential area if they so wished.
- The practice hosted some services on site to facilitate better access for patients. This included a weekly Citizens Advice Bureau session; podiatry (for foot assessments on patients with diabetes); mental health talking therapies; and a leg ulcer clinic provided by the district nursing team.
- The practice hosted a physiotherapy service on site three times a week. The practice had referred 310 patients to the physiotherapy service in the last 12 months, and patients could also self-refer for an assessment. Waiting times were approximately between six and eight weeks. From August 2016, the physiotherapist had started to see patients from other practices who resided locally to enhance local access arrangements.
- Same day appointments were available for children and those patients with medical problems that required them to be seen urgently. Longer appointments could be booked for those patients with more complex needs. Home visits were available for older patients and others with appropriate clinical needs which resulted in difficulty attending the practice.
- The practice provided care for residents at two local care homes. All patients had a care or management plan in place. One of two GPs routinely visited each home on a fortnightly basis to review patients as required, including reviews of prescribed medicines GPs responded promptly to any urgent requirements which

Good

Are services responsive to people's needs?

(for example, to feedback?)

arose between visits. We spoke with representatives from both homes. Both expressed they were highly satisfied with the service they received, and that excellent communication channels were in place.

- The surgery produced a patient newsletter to provide updates about the practice, and information on services. The practice website had been recently updated and acted as a useful source of information for patients.
- Translation services were available for patients whose first language was not English.

Access to the service

The practice opened daily from 8am until 6.30pm. Extended hours opening was available every Tuesday and Wednesday evening until 8pm. The practice closed one Wednesday afternoon each month for staff training.

Scheduled GP morning appointments times were available from 8.40am until 10.50am with appointments being added for urgent consultations offered on a 'sit and wait' basis from 11am. Telephone consultations were provided between 11.45am and 12.30pm. Afternoon GP surgeries ran approximately from 2.30pm to 5pm. Extended hours appointments on Tuesday and Wednesday evenings were available between 6.30pm and 7.20pm.

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

- 65% of patients usually got to see or speak to their preferred GP, compared to the CCG average of 60% and national average of 59%.
- 76% of patients found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 88% and a national average of 85%.
- 78% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 86% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.

Staff informed us that patients could book ahead up to four weeks in advance to see a GP or a nurse. On the day of our inspection, we saw that the next available routine GP appointment was available that day, but beyond that it was in seven working days' time. However, patients were able to ring back the following morning when additional consultation slots would be released. Ongoing monitoring of capacity and demand was in place and action was taken as appropriate to respond to this – for example, the use of a locum GP. Patients we spoke with on the day of the inspection were generally positive about their experience in obtaining an appointment. Some patients said their allocated appointment time often ran late, but they were aware that this was due to the doctor giving the patient time to discuss their concerns. Patients said they were kept informed when the appointment schedule was delayed. Some patients said that they were aware that longer appointments could be booked to discuss more than one issue, but had not chosen to do this. Feedback received on comment cards expressed satisfaction with the appointment system, and patients said they could usually obtain an appointment on the day when they needed one.

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 person that co-ordinated the complaints process. Clinicians always reviewed any complaints of a clinical nature.
- We saw that information was available to help patients understand the complaints system in the waiting area.

We looked at a selection of complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. The practice recorded all complaints, including those which were resolved within the practice before becoming formalised into a complaint. This ensured that lower level concerns were reviewed and used as a learning tool. The practice offered to meet with complainants to discuss their concerns whenever appropriate. Complaints were dealt within designated timescales and discussed at staff meeting. Some complaints were used as part of a significant event analysis review with the patient's consent. An annual review of complaints was undertaken which

Good

Are services responsive to people's needs?

(for example, to feedback?)

provided the opportunity to determine any recurring themes. Lessons were learnt and shared with the team following concerns and complaints, and action was taken to as a result to improve the quality of care. For example, the practice had received a complaint about appointment times running late. The practice amended the self check-in screen to display the approximate waiting time to ensure the patient was informed.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The service had developed very specific and clear aims and objectives. A mission statement was available which could be seen on the website, and was on clear display with the practice reception area. This reflected a commitment to delivering excellent patient care in a professional and safe environment, and ensuring that patients were treated with courtesy, consideration and respect.
- The practice held a partners' meeting with the practice manager in the evening, approximately every six weeks. This reviewed key issues relating to the practice business, and notes from the discussions were documented. In addition, each of the five partners rotated a fortnightly meeting with the practice manager to provide support with more strategic issues.
- Whilst the practice did not have a written business plan, the partners and management had a clear vision for the future which they were able to articulate during our inspection. For example, the partners had aspirations to develop their site in accordance with the local CCG strategy for 21st century care. This would enable the practice to provide or host more services in the premises meaning that care could be provided closer to home for patients.
- There was a focus on succession planning for both GPs and nurses to ensure service viability and continuity for patients. For example, the practice was reviewing arrangements in view of the senior partner retiring in 2017.
- The practice worked with other local GP practices, and was also part of a local GP federation. However, the partners were passionate about retaining their own practice identity and recognised the value they brought to their local community by understanding their patients' particular needs. The partnership therefore focused upon strengthening the existing service to benefit their patients.

Governance arrangements

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

- There was a clear team structure in place, and staff were aware of their own roles and responsibilities. GP partners had defined lead areas of responsibility, and acted as an expert resource for their colleagues. A salaried GP was the designated practice prescribing lead.
- Systems were in place for identifying, recording and managing risk, and implementing mitigating actions.
- A wide range of practice specific policies were implemented and were available to all staff. The practice manager had developed well organised systems to manage practice information. However, processes to record and provide access to clinical meeting minutes required strengthening. The practice had purchased an electronic document management system which would help to achieve this.
- An understanding of the performance of the practice was maintained which included the analysis and benchmarking of QOF performance, and referral and prescribing data. Actions were undertaken when any variances were identified.

Leadership and culture

- The partners engaged with their CCG and worked with them to enhance patient care and experience. One partner was the locality lead GP and attended the Primary Care Development Group as the representative for the Chesterfield GP practices. The practice manager attended the local practice managers' meetings.
- The partners and practice management demonstrated they had the experience and capability to run the practice effectively to ensure high quality care. Each Partner had responsibility for particular QOF indicators, clinical areas and also held a non-clinical role, with a brief for areas such as staffing, finance, training, IT and CCG.
- The partners emphasised the value of mutual respect for their team in order for the practice to work effectively. The practice upheld an ethos that staff needed care to give the best care, and we were provided with examples to support this.
- Staff told us there was an open culture within the practice and said the partners and practice manager

Are services well-led?

Good

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

were approachable, and always took the time to listen to all members of staff. Staff said they felt respected, valued and supported by the partners and managers in the practice.

- Staff told us the practice held monthly administrative team meetings, and that they had the opportunity to raise any issues at these meetings and felt confident and supported in doing so. Clinicians had a separate meeting to focus upon clinical issues on the same afternoon when the practice closed for training. The whole practice team would meet together to review incidents and undertake mandatory training sessions. Minutes from this meeting were documented. The practice manager met weekly with the nurse manager.
- Staff we spoke with told us that the practice was a good place to work, and the team supported each other to complete tasks. Each year, staff participated in an annual team building event which often took the form of a group walk and treasure hunt. Social events took place periodically which supported a strong team spirit within the practice.

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

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

- The practice had gathered feedback from patients through patient surveys and on the NHS Choices website; via complaints received; a suggestion box; and responses received as part of the Families and Friends Test (FFT). The FFT is a simple feedback card introduced in 2013 to assess how satisfied patients are with the care they received. During 2015, 134 responses were provided and 99.3% of patients said they would be 'extremely likely' or 'likely' to recommend the practice to others. The practice was not routinely providing feedback to patients on the outcomes from surveys and the FFT.
- The patient participation group usually met on a bi-monthly basis, although recent meetings had been less regular. The PPG had a membership of 18 core members who regularly attended meetings, supported by an extended virtual network of ten members. The practice manager and one of the GPs would attend these meetings. There was a designated display board for the PPG within the main waiting area. This focused on promoting health information, rather than highlighting the PPG's achievements. The PPG had designed patient surveys and analysed these jointly with the practice to produce an annual action plan. For example, a survey indicated patients were experiencing problems with the telephone system. The PPG then helped the practice to select a new system which provided options for different services when patients rang the surgery, rather than being placed on hold. The PPG influenced other developments within the practice. For example, arranging for a variety of chairs of differing heights to be available within the waiting area. The PPG to raised funds for the practice which had resulted in additional equipment being purchased to enhance patient care.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- Feedback from GP registrars had been very positive about their placement within the surgery, and had resulted in the practice being awarded the second best feedback within the deanery.