

The Osmaston Surgery

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Osmaston Surgery on 12 February 2016. Overall the practice is rated as good.

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

- The appointment system was flexible and ensured that patients who requested to be seen on the same day were.
- The practice had good facilities including disabled access. Patients who could not manage the stairs were seen on the ground floor.
- Information about services and how to complain was available, however, not in a format that could be understood by all patients. The practice sought patient views about improvements that could be made to the service, including having a patient participation group (PPG).
- The practice used interpreting services enabling patients whose first language was not English to access the services available. However, access to written information in other languages was not readily available.
- The practice proactively managed care plans for some vulnerable patients and had effective management strategies for patients at the end of their life.
- There were systems in place to reduce risks to patient safety for example, infection control procedures.
- Staff identified a clear leadership structure, good team work, and felt supported by the management.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. There was a training programme however; training in

Summary of findings

the Mental Capacity Act 2005 had not been provided. Senior staff provided assurance of their competencies in mental capacity assessment through case examples.

- The practice performance in relation to the management of patients with long term conditions, learning disabilities, and people experiencing mental health was mixed and exception reporting in these areas was high. The practice staff were unable to inform us what they would do to try and reduce this.

The areas where the provider must make improvement are:

- Take proactive steps to ensure patients receive safe care and treatment by reviewing exception reporting to mitigate the risks to ensure their health and wellbeing.
- Ensure patients with learning disabilities receive an annual health review with care plans written.
- Improve the identification of and support to carers.

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?

The practice is rated as good for providing safe services.

There were processes in place to report and record safety incidents and learn from them. Staff were aware of the systems in place and were encouraged to identify areas for concern, however minor. There was a strong culture of education and shared learning through the practice.

Risks to patients were assessed and well managed. Infection control procedures were completed to a high standard. There were enough staff to keep patients safe.

Each day a duty doctor was available, this doctor held a co-ordinating role, enabling responsive action to any patient with an urgent need and support to nursing and reception staff. They were also available for other health professional to seek clinical advice regarding patients.

Good



Are services effective?

The practice is rated as requires improvement for providing effective services.

Data from the Quality and Outcome framework showed high exception reporting when compared with other practices in the locality. The practice did not have a co-ordinated plan to review and address this.

The practice performance in respect of undertaking annual reviews for patients with learning disabilities was low at 33%.

Staff referred to guidance from the National Institute for Health and Care Excellence.

Staff had received training appropriate to their roles, any further training needs had been identified, and training was planned. There was evidence of appraisals and personal development plans for all staff.

Staff worked with multidisciplinary teams including community nurses, health visitors, care co-ordinator, and a mental health care for the link worker for older people.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services.

The GP national patient survey data published in January 2016 showed that patients rated the practice in line with others for several

Good



Summary of findings

aspects of care. For example, the percentage of patients who usually had an appointment or spoke with their preferred GP was 56%. This was 1% above the Clinical Commissioning Group (CCG) and national average.

Patients told us they were treated with compassion, dignity, and respect and they were involved in care and treatment decisions. We saw that staff treated patients with kindness and respect and in a way that was individual to those patients that needed extra support.

Confidentiality was maintained. The practice demonstrated that they prioritised patient centred care.

The practice performance to identify and support carers was low. They had less than one percentage of patients recorded.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Reports from the linguist services for a 12 month period during 2015 showed that the practice had used translation services for 51 different languages. The practice showed us they were aware of the needs of their practice population, and tailored their care and services accordingly.

The practice staff recognised that they served an area of high deprivation and this increased the importance of good health care.

Evening appointments were available on four days of the week and the GPs and nurses offered appointments on Saturday mornings. GPs were flexible with the appointment system to ensure that patients were seen on the day if requested. Telephone consultations and home visits were available when necessary.

The premises were suitable for patients who had a disability or those with limited mobility.

There was a complaints system in place that was fit for purpose, complaints received had been dealt with in a timely and appropriate manner.

Good



Are services well-led?

The practice is rated as good for being well-led.

It had a clear vision and strategy. There was a clear leadership structure and staff felt supported by the management.

The practice had a number of policies and procedures to govern activity and held regular team meetings. There was a system in place to monitor and improve quality and identify risk. Staff had received inductions and regular performance reviews.

Good



Summary of findings

There was evidence of an educational and learning culture throughout the practice for all staff.

The practice collated and acted on feedback from patients, through the patient participation group, surveys and direct contact with the patients.

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

The practice is rated as good for the care of older people.

The practice offered proactive, personalised care to meet the needs of the older people in its population. Home visits were available for those unable to attend the practice. Continuity of care was maintained for older people through a stable GP workforce and personalised patient centred care.

The practice provided dedicated visits to a local care home ensuring that patients' health care was managed proactively. Two hundred and fifty of those patients identified by the practice as being at risk of unplanned hospital admissions had a comprehensive care plan in their medical records.

Phlebotomy services were provided at the surgery enabling patients to have blood samples taken without the need to travel to the community service.

We saw evidence that the practice was working to the Gold Standards Framework and proactively managing care plans for those patients with end of life care needs.

The practice performance for indicators relating to patients with a diagnosis of osteoporosis was 100%. This was 4.7% above the CCG average and 8% above the national average. Exception reporting in one of the two indicators was above the CCG and national average. The exception reporting percentages for this indicator ranged from 9.9% below to 17.4% above the CCG average.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Nursing staff had lead roles in chronic disease management. The practice exception reporting was higher when compared with other practices in the locality. For example, the practice performance in respect of patients with a diagnosis of chronic obstructive pulmonary disease was 97.1% this was comparable with the CCG and national averages, however exception reporting in 3 of the 5 indicators was above the CCG and national average. The exception reporting percentages for this indicator ranged from 1.9% below to 24.9% above the CCG average.

Good



Summary of findings

Patients that attended had a structured annual review to check that their health and medication needs were met. Nurses with a prescribing qualification made changes to medication, without the patient always needing to book a second doctor's appointment.

Longer appointments were available if required. Practice staff followed up patients by telephone who did not attend their appointments.

Families, children and young people

The practice is rated as good for the care of families, children, and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young patients who had a high number of A&E attendances.

Young children were given open access for appointments enabling them to be seen without delay.

Immunisation rates were below local averages for some standard childhood immunisations. For example,

- Under two year olds ranged from 90.2% to 95.6% compared with the CCG average of 93.7% to 97.4%.
- Five year olds from 78.9% to 97.6% which was below the CCG average of 93.9% to 97.6%.
- Appointments were available outside of school hours and the premises were suitable for children and babies. We saw examples of joint working with midwives, health visitors, and school nurses.

The GPs and practice nurses offered a full range of family planning and women's health services.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of the working age population, including those recently retired and students had been identified, and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Evening and weekend appointments were available with GPs and nurses.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice did not restrict patients to certain

Good



Summary of findings

appointment times to attend for their annual reviews; patients who worked were able to book at times that were convenient to them. Telephone consultations were available for those patients who wished to seek advice from a GP.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data showed:

- The number of women screen for breast cancer was 73.9% which was lower than the CCG average of 78.5% and higher than the national average of 72.2%.
- The number of patients screened for bowel cancer was 49.9% which was significantly lower than the CCG average of 61.4% and lower than the national average of 58.3%.

Health checks were available for those who requested them.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It offered longer appointments and carried out annual health checks. Only thirty three percent of patients with a learning disability had received an annual review; the practice had developed a new system and planned to improve on this.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. We saw the practice provided vulnerable patients with information about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse or neglect in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Reception staff were intuitive to the needs of this group of patients and demonstrated that they had a personalised approach to helping them. For example, appointments for patients that were experiencing poor mental health were arranged at times they could be accompanied if needed.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Good



Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Staff told us that 77% of patients with a diagnosis of dementia had received advance care planning, including end of life care and had received an annual review.

Same day appointments and telephone triage with a GP was offered to ensure that any health needs were quickly assessed for this group of patients.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for patients with mental health needs and dementia.

The practice actively collaborated with other local GP practices to increase the community mental health nursing resource.

The practice performance in relation to mental health was 100%; this was 3.1% above the CCG average and 7.2% above the national average. However, exception reporting was above both the CCG and national averages in all indicators. The exception reporting percentages for this indicator ranged from 8.9% to 18.3% above the CCG average.

Summary of findings

What people who use the service say

The national GP patient survey results published on 7 January 2016 showed the practice was performing below the local and national averages. Three hundred and forty-nine survey forms were distributed and 106 were returned. This represented a 30% completion rate:

- 59% found it easy to get through to this surgery by phone compared with a Clinical Commissioning Group (CCG) average of 74% and a national average of 73%.
- 74% were able to get an appointment to see or speak to someone the last time they tried (CCG average 86%, national average 85%).
- 83% described the overall experience of their GP surgery as good or very good (CCG average 87%, national average 85%).

- 74% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 80%, national average 78%).

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 22 comment cards which were all positive about the standard of care received.

We spoke with four patients prior to the inspection who said they were happy with the care they received and thought staff were approachable, committed, and caring.

Areas for improvement

Action the service **MUST** take to improve

- Take proactive steps to ensure patients receive safe care and treatment by reviewing exception reporting to mitigate the risks to ensure their health and wellbeing.
- Ensure patients with learning disabilities receive an annual health review with care plans written.
- Improve the identification of and support to carers.

The Osmaston Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead Inspector. The team included a GP specialist adviser, and a second CQC inspector.

Background to The Osmaston Surgery

The Osmaston Surgery provides a range of medical services to approximately 15,600 patients living in the City of Derby.

The practice holds a General Medical Services (GMS) contract to provide GP services and is a training practice with two GP trainers. A training practice has GP Registrars working in the practice; a GP registrar is a qualified doctor who is undertaking further training to become a GP. A trainer is a GP who is qualified to teach, support, and assess GP registrars. There is currently one GP registrar working in the practice.

Data from Public Health England shows the practice serves an area where income deprivation affecting children and older people is higher than the England average. Additionally, the area has a higher than average number of patients aged 20 years to 40 years. A report from the linguistics provider showed that the practice had used translators for 51 different languages.

The practice has a team of 12 GPs meeting patients' needs. Ten GPs (six male and four female) are partners and they hold managerial and financial responsibility for the practice. One male salaried GP and a long term locum are employed. In addition, there are six practice nurses (this includes a nurse manager and independent nurse

prescribers) and one phlebotomist. There is a practice manager, information technology and administrative manager and a team of 15 administrative and reception staff. One reception post was vacant.

Patients using the practice have access to a range of services and visiting healthcare professionals. These include health visitors, midwives, and a community care co-ordinator.

Appointments are available Monday, Tuesday, Thursday, and Friday from 7.30 am to 8 pm and on Wednesday from 7.30 am to 5 pm. Appointments are available on Saturday 8 am to 12 pm.

Outside of practice opening hours Derbyshire Health United provides urgent health services. Details of how to access emergency and non-emergency treatment and advice is available within the practice and on its website.

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

How we carried out this inspection

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 were provided for specific groups of people and what good care looked 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)

Before our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 12 February 2016. During our inspection we spoke with a range of staff including three GPs, one GP Registrar, nursing, reception, and administration team staff. We spoke with four patients who used the service; three were members of the patient participation group and the deputy manager of a local care home. We observed how patients were cared for and reviewed 22 comment cards where patients shared their views and experiences of the service.

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

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents comments and complaints received from patients.

- The practice had policies and procedures for reporting and responding to accidents, incidents, and near misses. These were accessible to all staff on the practice electronic system. A specifically designed form (including impact and likelihood rating tool to establish the seriousness of incident), was available electronically or in paper form for staff to report incidents and near misses. These were reported to the practice manager or GP partners.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports, and minutes of meetings where these were discussed over the past 12 months. This showed the practice had managed these in an open and transparent way, consistently over time and could evidence a safe track record over the long term. Twenty- two events had been recorded. These were a mixture of clinical, and administration. Each event was well documented and evidence of actions and shared learning was noted. For example, a GP had omitted to follow the process for a patient to be contacted regarding a follow up blood test requested by the hospital. The administrative manager sent a reminder to all GPs detailing the process; including creating an electronic follow up task to check the patient had attended.

Overview of safety systems and processes

The practice had robust systems and processes in place to keep people safe, which included:

- Arrangements to safeguard vulnerable adults and children from the risk of abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding and the practice held quarterly safeguarding meetings which included other health care

professionals such as the midwife and health visitor. Staff knew who to contact and report concerns to both internal and external agencies. Vulnerable patients were highlighted on the practice electronic system. This included children subject to child protection plans and patients with a diagnosis of dementia.

- A notice was displayed in the waiting room, advising patients that nurses or staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). 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.
- There was a health and safety policy available with a poster in the office. There were four fire marshals and a fire risk assessment had been carried out in November 2015. The fire extinguishers were checked in October 2015, and a fire evacuation drill had been carried out in February 2016.
- Appropriate standards of cleanliness and hygiene were followed. In addition to contract cleaners, the practice employed two cleaners and all staff had received infection prevention training. We observed the premises to be visibly clean and tidy. The practice nurse was the infection control clinical lead and had received training appropriate to their role. They had liaised with the local infection prevention teams to keep up to date with best practice.
- A sharps injury policy was in place and staff were aware of the actions to take. There was a record of the immunisation status of staff. Clinical waste was well managed; waste bags were secured and stored in the cellar which was not accessible to members of the public. A comprehensive infection control audit was undertaken in 2015, identified actions from the audit completed in 2014 were reflected and showed significant improvement. For example, the lead nurse held training for the reception staff on cleaning up bodily fluids; this included the use of personal protective equipment and spillage kits. Staff we spoke with confirmed they had received annual infection control training.
- Medicines were stored safely and records of fridge temperatures were reviewed. Stock levels and expiry dates of medicines were checked monthly. The quantities, batch number, and expiry date were recorded on the computer; this information had been

Are services safe?

used to check if the practice held any vaccines that were subject to recall identified through a medicines safety alert. The practice did not hold any controlled medicines. All medicines that we checked were in date.

- Regular medicines' audits were carried out with the support of the local Clinical Commissioning Group (CCG) pharmacy team to ensure the practice was prescribing in line with best practice guidelines. The nurses used Patient Group Directions (PGDs) to administer vaccines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated and signed.
- There was a repeat prescription policy for non-clinical staff to follow. New medicines or alterations to existing medicines were actioned by clinical staff. Uncollected prescriptions were highlighted to the GPs to ensure patient safety. Prescription pads and boxes of prescription paper were securely stored and recorded.
- The three staff files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service for all staff.
- The practice recognised that they served an area with higher health needs. To meet this demand and to offer continuity of care the GPs discussed and agreed any leave. This ensured that there were enough regular GPs to meet the needs of the patients. Patients told us they had received good care from these GPs. Staff told us there were sufficient numbers of staff on duty and that staff rotas were managed well. Many of the practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and could be available for annual leave and sickness absence cover. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring risks to patients

The practice had risk assessments in place to monitor the safety of the premises. For example, control of substances hazardous to health and infection control.

- Testing for legionella was undertaken in February 2015. We noted that two actions were still outstanding, for example warning notices of hot water at the wash basins were not in place. The practice staff told us they had ordered these and would put them up as soon as they arrived. Legionella is a bacterium found in the environment which can contaminate water systems in buildings and cause harm to patients.

The practice carried out minor surgery and consultations in an adjacent building which they leased. Routine water temperatures checks identified that the water was not reaching the recommended temperatures regarding precautions against legionella. A risk assessment had been carried out and the practice staff decided not to use the premises until essential maintenance had been completed. The practice staff told us that they were in negotiation with the landlords.

- All electrical equipment was checked in January 2016 to ensure that it was fit for purpose. Clinical equipment was calibrated in July 2015 to ensure it was working properly.

Arrangements to deal with emergencies and major incidents

- There was a messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Staff received annual basic life support training and there were emergency medicines available in the treatment room including a defibrillator and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and available in the practice and held in the homes of the GP partners.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and locally produced quality standards. The practice held a daily clinical meeting where GPs discussed patients, gained peer support and shared best practice.

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 recently published results showed that the practice had achieved 91.9% of the total number of points available, with an exception reporting rate of 15.8% which was above both local and national averages. The exception reporting rate is the number of patients which are excluded by the practice when calculating achievement within QOF.

The practice told us that the communication and cultural barriers resulted in higher exception reporting for QOF indicators but there was no clear plan in place to address this to improve health outcomes for patients.

Data from 2014/15 showed;

- Performance for diabetes related indicators was 83.9%
The practice had a higher rate of exception reporting, for six of the 10 indicators related to diabetes. The exception reporting percentages for this indicator ranged from 6.4% below to 10.9% above the CCG average.
- The percentage of patients with hypertension (high blood pressure) having regular blood pressure tests was 77.8% which was 20.8% below the CCG average and 20% below the national average. Exception reporting for this indicator was similar to the CCG and England average.
- Performance for mental health related indicators was 100% which was 3.1% above the CCG average and 7.2% above the national average. The practice had a higher

rate of exception reporting for all six related to mental health. The exception reporting percentages for this indicator ranged from 8.9% to 20.1% above the CCG average.

The practice recognised that the performance in relation to hypertension indicators was low. They had identified that compliance and follow up was a challenge. In order to manage patient safety and ensure patients attended, the GPs reduced the quantity of medicines that the patients were able to obtain through the repeat prescription service. In some cases the quantity had been reduced to seven days supply to help ensure that patients made contact with the practice for their medicines to be reviewed. GPs and nurses were aware of the need to make every consultation count and opportunistically addressed high blood pressure and lifestyle choices with patients.

The practice nurse had been trained to support patients with diabetes including supporting patients starting with insulin injections. Appointments for one hour were booked and with an interpreter if needed. This enabled the practice to ensure that these patients were managed close to home and with staff who knew them and could offer continuity of care. This was beneficial to the patients whose first language was not English. For patient education referrals were made to a local service, Diabetes and You (DAY).

Thirty-three percent of patients with learning disabilities had received an annual review in the past 12 months, to improve this further; a GP we spoke with shared the revised recall system for patients. At the time of the inspection, the practice had not yet implemented this. Staff we spoke with told us that if patients with learning disabilities were unable to access appointments at convenient times for them to attend, the reception staff asked the GP to contact the patient direct to arrange a suitable time.

Data from the CCG (Derby Advanced Commissioning locality Pack issued December 2015) showed that the practice was not an outlier for secondary care activity. As a result of allowing open access for children under five years old, the practice had reduced the number of emergency admissions to hospital.

Clinical audits demonstrated quality improvement.

Are services effective?

(for example, treatment is effective)

- The practice had a comprehensive audit programme and used audits to monitor and improve the quality of care, safety, and systems and to drive improvements. There had been 13 clinical audits completed in the last 12 months.

We reviewed two completed audits where improvements were identified and changes had been implemented and monitored. For example, one of these related to monitoring patients who had been prescribed a medicine to help with weight loss. This showed an improvement in GPs follow up and monitoring of patients to 100% from 47% of patients.

Effective staffing

Staff had the skills, knowledge, and experience to deliver effective care and treatment.

- The practice had a role specific induction programme for newly appointed members of staff which included such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings, and reviews of practice development needs. Staff appraisals had been carried out in the past 12 months. The GP partners and the line managers undertook all staff appraisals. Staff we spoke with told us they valued this and found the time spent beneficial. The practice had a system to manage staff training needs and updates. This included fire safety, safeguarding, and infection control. Staff we spoke with confirmed they were given protected time for training and any request for additional training was considered and usually granted. For example, a non-clinical staff member had expressed an interest in understanding the needs of patients with learning disabilities. Two staff members attended a course; as a result a comprehensive set of written material appropriate for patients with learning disabilities was compiled.

Coordinating patient care and information sharing

- Referrals for patients to secondary care or other agencies were well managed. Most referrals to secondary care were completed via the choose and book system (C&B). C&B is an electronic system between primary and secondary care and does not require any paper copies to be sent. This system increased the speed of referral receipt and reduced the

risk of delay or confidentiality breaches. Staff told us that they would, if necessary use the translation services to ensure that patients were provided with choice of where to go.

- The practice staff worked with other services to meet patients' needs and manage those patients with more complex needs. This included community nursing teams and health visitors. The practice worked to the Gold Standards Framework when co-ordinating end of life care. To monitor the patient's journey through end of life, the practice staff proactively flagged patients' records, using a traffic light system. This enabled clinicians to see easily if a patient was palliative but well or if palliative and less well.
- Regular meetings with the wider health team were held to manage and plan patients' care. A community care co-ordinator attended the practice four days a week. The care co-ordinator met or spoke with vulnerable patients and was able to co-ordinate other agencies to provide the care that was needed. The GPs and staff we spoke with told us that this service had benefitted patients, for example, a patient with a particular health need was experiencing a crisis and needed support. The patient did not meet the criteria for admission to hospital or referral to community mental health teams. The care co-ordinator was able to arrange for emergency supplies of food to be delivered and for support to self-manage at home.
- Special patient notes/ comprehensive care plans were completed by the practice on the electronic system and this ensured that emergency services staff had up to date information of vulnerable patients. We reviewed a care plan and found it to be comprehensive, the practice had 250 patients on their unplanned admissions register with an up to date care plan in place.
- Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals. All communication was sent to the GPs, who took any required actions. We reviewed this system and found in general this was well managed to ensure that patients were safe.
- We noted that the practice had recognised that one partner was an outlier in the time for reviewing and filing letters which could pose a risk to patients. An audit was

Are services effective?

(for example, treatment is effective)

undertaken in September 2015, we saw and the practice recognised that an improvement had been made, however, a second audit needed to be completed to ensure that the partner's performance in this area had improved. The lead partner told us that this was closely monitored to ensure that clinical oversight of hospital letters and test results were timely and well managed to keep patients safe.

Consent to care and treatment

- Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance. Staff had not received training in the Mental Capacity Act 2005 however; GPs we spoke with demonstrated a clear understanding and knowledge. When providing care and treatment for children and young patients, assessments of capacity to consent were carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. All staff were aware of Gillick competency and applied this in practice. Staff recorded patients' consent in the medical records.

Supporting patients to live healthier lives

The practice's uptake for the cervical screening programme was 77.15% which was lower than the national average of 81.83%. The practice recognised this, and had completed cycle one of an audit which identified challenges in respect of cultural issues and communication. The audit identified that information leaflets in some other languages were available on the NHS choices web site; however, we did not

see that these were available to patients. The practice planned to use a targeted questionnaire to gather more information and planned to continue work with the CCG in respect of this unmet need.

Childhood immunisation rates for the vaccinations given were below the CCG/national averages. Immunisation rates were below local averages for some standard childhood immunisations. For example,

- Immunisation rates for under two year olds ranged from 90.2% to 95.6% compared with the CCG average of 93.7% to 97.4%.
- Immunisation rates for five year olds ranged from 78.9% to 97.6% which was below the CCG average of 93.9% to 97.6%.

Staff were aware of this and with the community health visitor and midwife encouraged patients to attend. The interpreting service would be used for those patients who did not speak English.

Patients could access appropriate health assessments and checks, however, the practice did not have information, in other languages to encourage or make the patients aware of this service. The practice had reviewed the clinical resources it had available and had decided not to proactively offer routine health checks to all patients aged 75 and over but did offer to those that were identified as vulnerable. Smoking cessation advice was included in the chronic disease annual reviews with patients by the practice nurse who had received appropriate training.

The practice actively encouraged patients to improve their lifestyles by signposting them to local Livewell Derby programme (smoking cessation, weight management and exercise).

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed staff being polite and helpful to patients. Patients we spoke with told us that they were treated with respect and dignity. The practice had a number of patients with complex needs, physical and mental health issues. The reception staff described personalised care that they offered to these patients. For example, a patient and their main carer were given appointments that were co-ordinated so that they could attend the practice at the same time.

The consultation and treatment room doors were closed during consultations and we observed that conversations taking place in these rooms could not be overheard. If patients wished to discuss a sensitive issue or appeared distressed the reception staff had access to a private room which they could use. There was a poster displayed in the waiting area that informed patients of this.

The patient Care Quality Commission (CQC) comment cards we received were mixed about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect, but some patients commented that they had experienced long waiting times to see the GPs.

We also spoke with three members of the patient participation group (PPG). The PPG are a group of patients who give feedback and engage with the practice in the delivery of the service. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. In particular they highlighted that the practice listened to them and that they felt valued by the management team.

Results from the national GP patient survey January 2016 showed patients felt they were treated with compassion, dignity, and respect. The practice was comparable with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% said the GP was good at listening to them compared with the Clinical Commissioning Group (CCG) average of 90% and national average of 89%.
- 86% said the GP gave them enough time (CCG average 88%, national average 87%).

- 93% said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%)
- 84% said the last GP they spoke to was good at treating them with care and concern (CCG average 86%, national average 85%).
- 97% said the last nurse they spoke to was good at treating them with care and concern (CCG average 93%, national average 92%).
- 84% said they found the receptionists at the practice helpful (CCG average 88%, national average 87%)

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received reflected similar views.

However, results from the national GP patient survey showed that the practice performed lower than the CCG and national average in respect of patients reporting their involvement in planning and making decisions about their care and treatment. For example:

- 78% 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%.
- 78% said the last GP they saw was good at involving them in decisions about their care (CCG average 83%, national average 82%)
- 80% said the last nurse they saw was good at involving them in decisions about their care (CCG average 87%, national average 85%)

Staff told us that translation services (face to face and telephone) were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified under 1% of the practice list as carers. Staff told us that they proactively asked if patients were carers or cared for, new patients were asked at registration, and clinical staff including community matrons and care co-ordinators identified patients. However, the low number of recorded carers did not assure us that these steps had been wholly successful.

The GPs discussed recent deaths at the daily lunchtime meeting and in the palliative care meetings. Staff told us that if families had experienced bereavement, their usual

GP or nurse contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The practice had compiled information written in an appropriate format for patients with learning disabilities. These included pictorial information sheets on how to book an annual review, the basic tests that would be carried out at the annual health check, for example weight, blood pressure, urine sample, and who to contact should they if became unwell (for example contact the doctor, 111 or ambulance).

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice offered NHS health care services to the population of patients living in Derby. A report from the linguist supplier of translation services showed that the practice had accessed translators of 51 different languages. In an eight month period in 2015 the report showed high use of translators in Urdu, Latvian, Polish, Slovak, Bengali, and Kurdish.

The practice staff recognised that this and cultural issues challenged them to engage effectively with patients to communicate the need to and benefits of attending annual reviews. The practice staff told us that they did access information in other languages but we did not see a range of information or leaflets readily available in other languages. The practice staff told us that this was an area that they were working with the CCG to identify resources for written translation services and how to address/resource this unmet need.

Staff at the practice worked hard to understand the needs of their patients. Both clinical and non-clinical staff demonstrated a clear understanding of the concept of personalised care for the patients according to their individual needs. For example, by allowing any patient who lived in Derby City to be registered at the practice, continuity of care including home visits for those who needed them was available to patients who moved within the city. All home visit requests were triaged by the duty doctor to ensure appropriate and timely response ensuring the safety of patients.

The practice operated over two floors within a four storey building. There was no lift available for patients but, staff told us they asked each patient, at the time of booking an appointment if they were able to manage the stairs or if they needed to be seen on the ground floor. We heard staff doing this during the inspection.

Services were planned and delivered to take into account the needs of different patient groups and to ensure flexibility, choice, and continuity of care. For example;

- There were longer appointments or home visits available for patients with a learning disability or dementia.

- Home visits were also available for older patients and others that needed one.
- Facilities for patients with disabilities were available. There were automatic doors, fixed and portable hearing loops, and appropriate toilet facilities in place.
- GP appointment lists were extended to meet the demand of patients that requested to be seen on the day.
- A duty doctor was available to meet the needs of any patient that required emergency treatment or for nurses who needed advice.
- An in house phlebotomy service was provided and this enabled patients to have samples taken without having to attend an alternative clinic.
- The GPs visited local care homes every week or more often as needed to see patients living there. This enabled the practice to offer proactive care. We received positive comments from staff about the service. For example, care staff were able to discuss concerns, however minor, with the GPs and felt that they were listened.
- Open access for children aged under five was available each day. This ensured that any children who were unwell did not wait too long for medical help.

Interpreter services (both face to face and telephone) were used for those patients whose first language was not English. Staff told us they booked interpreters in advance to be present during appointments and used telephone interpreting services mainly when this could not be arranged in time. They gave us an example of using an interpreter to help establish the vaccinations needed by children during one appointment and again at the appointment when the vaccinations were given. Although some information was available to patients in formats that they could understand, it was not always in a variety of languages commonly spoken by the patient population.

- The practice used the local community to provide support to patients living in vulnerable circumstances. For example, a vulnerable patient experiencing a crisis had been identified, staff worked with a local church community to enable them to provide a patient with the treatment and care they needed.
- The practice engaged with the CCG in identifying ways to meet the challenges of providing services to an area of high deprivation and unmet need.

Access to the service

Are services responsive to people's needs?

(for example, to feedback?)

The practice was open between 7.30 am and 8 pm Monday, Tuesday, Thursday, and Friday. From 7.30 am to 5 pm on Wednesday. Appointments were available for GPs and nurses on Saturday morning from 8 am to 12 pm. This met the needs of those patients who were not able to attend during week days or during day opening.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were mixed compared to local and national averages.

- 80% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 77% and national average of 75%.
- 59% patients said they could get through easily to the surgery by phone (CCG average 74%, national average 73%).
- 56% patients said they always or almost always see or speak to the GP they prefer (CCG average 55%, national average 59%).

The staff we spoke with were aware of the difficulty patients did have with getting through on the telephone,

during busy times staff who would have been undertaking administration tasks would answer the telephones. At the time of the inspection the practice were recruiting an additional staff member.

Patients we spoke with told us that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for dealing with these.

We saw that information was available to help patients understand the complaints system. There were leaflets and posters displayed in the waiting area and information was available on the web site. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We saw that learning from complaints was well established and that a comprehensive record had been maintained. There had been 21 complaints in the past 12 months, we looked at two complaints received in the last 12 months and found these had been dealt with in accordance with the practice's own complaints procedure.

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 that included providing the best family medical care within the resources available to them. To provide a safe and supportive environment for the staff and patients and to continually improve.

Governance arrangements

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. The partners each had lead roles within the practice these were both clinical and managerial.
- Practice specific policies were implemented and were available to all staff.
- The management team maintained a comprehensive understanding of the performance of the practice. The partners acknowledged that the exception reporting was high but we did not see an action plan that assured us that the practice team were working together to improve this.
- A programme of continuous education, and clinical and internal audit was used to monitor quality and to make improvements. Meetings were held every two weeks.
- There were robust arrangements for identifying, recording, and managing risks, issues, and implementing mitigating actions.

Leadership and culture

The GP partners supported by the salaried GPs had the experience, capacity and capability to run the practice and ensured high quality care. Safe, high quality and compassionate care was prioritised. The GPs were visible in the practice and encouraged an open and transparent environment. Staff told us that they were approachable and always took the time to listen.

The partners and staff recognised that communication needed to be strengthened through the practice to optimise the knowledge and resources available to them to enhance patient care. For example, the administrative staff had complied information for patients with learning disabilities however, not all staff were aware of this valuable resource.

The practice held regular meetings and this included a daily clinical meeting for GPs to distribute home visit requests, discuss patients, and offer peer support and quarterly practice team meetings. Staff we spoke with told us they valued this protected time. Meeting minutes were accessible for staff. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at meetings or speak directly to the GPs or the management team. They felt confident in doing so, and felt supported if they did. Staff said they felt respected, valued, and supported. All staff were encouraged to identify opportunities to improve the service delivered by the practice.

There was evidence that education and development was well managed. A robust electronic calendar had been created to give all staff the opportunity to attend meetings and training.

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 them in the delivery of the service.

Feedback from patients had been gathered through the patient participation group (PPG), surveys and complaints received. The membership of the PPG was low, the practice advertised on the web site, posters in the waiting areas and through the practice newsletter to encourage more patients to become involved. However, there was no information in other languages to encourage those whose first language was not English. We saw minutes from meetings held (these were available on the website), where the practice had discussed issues such as access, and how to request home visits.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Safe care and treatment</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• The practice did not have a co-ordinated plan to review the high exception reporting, mitigating the risks, and ensure patients health and wellbeing.• The practice did not have a robust system implemented to ensure patients with learning disabilities received an annual health review with care plans written.• The practice did not have a robust system to identify and to support carers. <p>This was in breach of regulation</p> <p>12(1)(2)(a)&(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.</p>