

Lister House at Chellaston

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?

Outstanding 

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 Dr Moss and Partners, Lister House at Chellaston on 18 October 2016. Overall the practice is rated as good.

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

- Dr Moss and Partners had taken over the practice in a 'caretaker' capacity since January 2016 and put in place improved governance structures and facilities for patients that were available at other locations already managed by Dr Moss and Partners. A new clinical team was put in place at the practice. Since our inspection Dr Moss and Partners have been offered a 10 year contract to provide services at Lister House at Chellaston. The practice is one of four sites managed by Dr Moss and Partners.
- We identified that Dr Moss and Partners had made significant improvements to this practice during the 'caretaker' stage and was responsive to the needs of the population, in particular for older people and for people experiencing poor mental health.
- The partners utilised creative methods to communicate changes, updates and practice news with staff and to encourage feedback. For example; they held Friday feedback sessions for staff to give feedback, and they produced a staff bulletin quarterly. Staff told us that this made them feel more involved and part of the team.
- The partners funded specialist services in order to help address the GP capacity issues they inherited at the practice; For example, a full time mental health nurse, and a full time advanced nurse practitioner (ANP) to coordinate activity in care homes. Both these roles freed up time for GPs to attend to other activities, but had not yet been fully analysed in terms of cost savings or patient benefit at this practice.
- There was an open and transparent approach to safety within the practice. Effective systems were in place to report, record and learn from significant events. Learning was shared with staff at regular meetings and through a staff bulletin.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.

Summary of findings

- The provider had developed and implemented a triage system for non-clinical staff to use in order to prioritise requests for urgent appointments, and ensure the patient could access the right clinician in the right timescale. The prioritisation tool was based on clinical algorithms and regularly reviewed and updated by clinicians. (clinical algorithms are a tool that uses an ordered sequence of steps, each step depending on the outcome of the previous one, to reach a decision) The triage system enabled patients to be prioritised according to their clinical need or directed to the most appropriate resource. The providers had just introduced this system from their other practice and it was anticipated that it would have a positive impact on patient satisfaction and clinician's time. The protocol had been commended by the CCG who were liaising with the provider to see whether it could be shared more widely.
 - There was a strong focus on continuous learning, improvement and education at all levels. Staff were proactively supported to acquire new skills and share best practice. This included: engaging with Health Education England and the clinical commissioning group in developing the training and qualifications for advanced nurse practitioners and advanced care practitioners in Southern Derbyshire; being part of a training hub and taking part in CCG pilot projects which included employing a pharmacist and design of specific pathways for long term conditions such as diabetes.
 - Outcomes for patients were generally in line with local and national averages.
 - Training was provided for staff which equipped them with the skills, knowledge and experience to deliver effective care and treatment.
 - Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
 - Patients told us they were able to get an appointment with a GP when they needed one, with urgent appointments available on the same day.
 - Feedback from patients and staff identified that services at the practice had improved since being managed by Dr Moss and Partners. A patient survey conducted by the practice after six months showed that 84% of respondents would be happy for Dr Moss and partners to continue to provide services at Chellaston and Coleman street surgeries.
 - Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns and learning from complaints was shared with staff
 - The practice premises were purpose built, had good facilities and was well equipped to treat patients and meet their needs. Services were designed to meet the needs of patients and additional services were being planned.
 - There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
 - The provider are partners with another local practice and Alexin Healthcare Limited in a training hub, that provides placements for medical students and student nurses in General Practice.
 - The provider engaged with their CCG and other stakeholders in pilot projects, For example; a practice nurse was working with the CCG to re-design a community based diabetes service; they provided mentorship for an Independent Prescribing Pharmacist to work at the practice.
- We saw areas of outstanding practice;
- A senior Nurse Practitioner (ANP) had been recruited to provide dedicated support to nursing home residents. The ANP worked closely with care home staff and practice GPs to review care for residents on an ongoing basis. In the four months since commencing the role, the practice told us that requests for GP visits had reduced and there had been a significant cost saving with regards to improved prescribing of nutritional supplement drinks. (There were plans to formally audit this after one year). A brief review of the work over a six week period showed that the ANP had completed; 11 'Do not attempt active resuscitation' (DNAR) agreements; 20 care plans; 22 face to face visit requests; 21 medicines reviews; 16 dementia reviews and two reviews for chronic illness.
 - The provider hosted and facilitated community based services from Lister House surgery which enabled care to be provided closer to home for patients. For

Summary of findings

example, since 2010, the provider had hosted a GP led community musculoskeletal assessment and treatment service which is accessible to patients registered with 26 local practices. Two of the GPs took a lead role with support from another local GP. The impact of this service provision included a 50% to 60% reduction in orthopaedic referrals to secondary care services.

The areas where the provider should make improvement are:

- The partners should review the need for contingency plans to cover absences so that administration staff are able to complete administration processes effectively.
- The partners should consider incorporating sufficient detail in their safeguarding meeting minutes to enable staff to access relevant information when they have not attended the meeting.

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.

Good



- There was an effective system in place to ensure significant events were reported and recorded. Lessons were shared with staff to make sure action was taken to improve safety in the practice.
- When things went wrong patients received support, information and apologies where appropriate. They were told about any actions to improve processes to prevent the same thing happening again.
- There were effective processes in place to safeguard vulnerable children and adults. Comprehensive documentation was made to patient records and these were accessible to relevant community staff, however, meeting minutes for their safeguarding minutes were brief and lacking in detail.
- Risks to patients were well assessed and managed within the practice.
- Appropriate recruitment checks had been carried out on recently recruited staff.
- There was effective management of medicines, including high risk medicines.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. The most recently published results in 2015/16 were not available because the information had not been submitted due to the new provider caretaker role being implemented in January 2016. The practice provided uncompleted data for 2015/16 which showed the practice had achieved 88% of the total number of points available. This was comparable with the CCG and national averages.
- Staff used current evidence based guidance and local guidelines to assess the needs of patients and deliver appropriate care.
- There was an ongoing programme of clinical audit within the practice. The audits undertaken demonstrated improvements in quality.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment and worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Results from the national GP patient survey were comparable with CCG and national averages
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Views of external stakeholders were positive about the practice and aligned with our findings.
- The provider funded a mental health nurse who provided an appointment for bereaved relatives routinely.

Good



Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

- Patients said there had recently been some improvement to the appointments system and that urgent appointments were available the same day. The practice had recently implemented a triage system to prioritise urgent requests.
- Staff used current evidence based guidance and local guidelines to assess the needs of patients and deliver appropriate care.
- The provider had recruited an Advanced Nurse Practitioner (ANP) to coordinate and manage care in care homes aligned to them.
- The provider funded additional roles and services to meet the needs of the practice population. For example, a mental health nurse. Feedback from external stakeholders indicated that this role had a positive impact on timeliness of support for patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Outstanding



Summary of findings

Are services well-led?

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

Good



- The provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. This was underpinned by clear business development plans and regular monitoring of areas for improvement and development.
- There was a clear leadership structure and staff felt supported by management. The provider had a wide range of policies and procedures to govern activity, and held regular business and weekly operational meetings to ensure oversight and governance was effective within the practice.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- One of the nurses worked with Southern Derbyshire CCG to design and implement a new community diabetes pathway. This work was ongoing and due to be analysed in November and implemented across Southern Derbyshire.
- There was a strong focus on continuous learning and improvement at all levels. This was an outstanding feature of the practice. Staff were proactively supported to acquire new skills and share best practice. This included: engaging with Health Education England and the clinical commissioning group in developing the training and qualifications for advanced nurse practitioners in Southern Derbyshire; taking part in CCG pilot projects and design of specific pathways for long term conditions such as diabetes.

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.

Good



The practice offered proactive, personalised care to meet the needs of the older people in its population. For example;

- All patients over 75 had a named GP.
- They worked closely with district nurses and community matrons to plan care. These teams were accommodated at the Lister House site, easily accessible and told us they had a good working relationship with the practice.
- A senior Nurse Practitioner (ANP) had been recruited to provide dedicated support to nursing home residents. The ANP worked closely with care home staff and practice GPs to review care for residents on an ongoing basis. In the four months since commencing the role, the practice told us that requests for GP visits had reduced and there had been a significant cost saving with regards to improved prescribing of nutritional supplement drinks. (there were plans to formally audit this after one year) A brief review of the work over a six week period showed that the ANP had completed; 11 'Do not attempt resuscitation' (DNAR) agreements; 20 care plans; 22 face to face visit requests; 21 medicines reviews; 16 dementia reviews and two reviews for chronic illness.
- The provider hosted and facilitated community based services from Lister House surgery which enabled care to be provided closer to home for patients. For example, since 2010, the provider had hosted a GP led community musculoskeletal assessment and treatment service which is accessible to patients registered with 26 local practices. Two of the GPs took a lead role with support from another local GP. The impact of this service provision included a 50% to 60% reduction in orthopaedic referrals to secondary care services.
- There was regular review of the palliative care register in accordance with local guidelines, and care plans were shared to enable appropriate care to be accessed quickly where required.
- The practice liaised closely with the community nursing team and a care co-ordinator to review patients at risk of unplanned admission. This enabled patients to receive coordinated care and be directed to services to assist them in all aspects of their lives to facilitate better health.

Summary of findings

- The provider had a contract with Southern Derbyshire Clinical Commissioning Group (CCG) to provide 'step down beds' in a local care facility for short term intermediate care. This facilitated early discharge which enabled patients to return to the community.
- The in-house phlebotomy service encouraged compliance for blood tests for people who found it difficult to travel to hospital.
- The practice supported events for carers and provided information for carers on their website.
- Urgent appointments were always available.

People with long term conditions

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

Good



- Long term conditions management was provided by a team of qualified nurses who took lead roles in specific chronic illness. The nurses had all received training to diploma or degree level in chronic disease management.
- The lead nurses for diabetes liaised with the practice GPs, the Integrated Diabetic Service, a Diabetic Specialist Nurse, a local diabetes consultant and the dietary service for advice and support
- The practice operated a comprehensive recall system to ensure patients' conditions were appropriately monitored. This was managed by a dedicated administrator.
- Appropriately monitored COPD patients benefited from having anticipatory drugs provided to reduce incidences of exacerbation.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

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

Good



- Systems were in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- A comprehensive immunisation and follow up immunisation program was in place which was managed by a dedicated

Summary of findings

administrator. The programme included a monthly checking process and up to two letters were sent by recorded delivery to parents where children had not attended for vaccination. The nurse lead for immunisations followed this up by contacting parents by telephone to discuss reasons for not attending and made a follow up appointment. If it was not possible to make telephone contact then the lead contacted the health visitor and an alert was placed on the child's record.

- Joint working was in place with midwives, health visitors and school nurses who were invited to regular meetings.
- Patient status alerts were used to identify vulnerable people.
- There were baby change facilities and a private room was made available for breast feeding.
- A support event for new mothers and parents to be is planned.
- The practice hosted a weekly health visiting clinic that was extended to children who were registered with other local practices as well as this one.
- The practice provided information on their website which signposted parents to a number of support services.
- The practice provided a comprehensive travel vaccination service, and was a designated yellow fever vaccination centre.
- Appointments were available on the day for children and were given a high priority in the triage protocol.

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, 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. This included;

- The practice was open from 8.00am to 6.30pm Monday, Tuesday Thursday and Friday and from 7.00am until 6.30pm on Wednesday. Appointments were from 8am to 12pm and 12.30pm to 6.30pm daily. Extended hours appointments were offered on Wednesday mornings from 7am to 8am. Access was also provided to on-line services via the practice's website.
- The practice communicated with patients by email and text and planned to introduce an enhanced electronic 2 way communication package in the near future.

Good



Summary of findings

- Patients were able to access a comprehensive musculoskeletal triage and treatment service which was provided at one of the local sites aligned with the practice. This was also made available to practices within the locality (City) by two GPs. This was supported by on site physiotherapy services.
- The provider hosted consultant led first outpatient spinal clinics operated by Royal Derby Hospital at one of the sites. This enabled care to be more accessible for patients and allowed a closer working relationship between practice GPs and the consultants.
- The practice was proactive in offering a full range of health promotion and screening that reflected the needs for this age group. There was a proactive recall system in place to follow up patients who did not attend their screening appointment. The dedicated nurse administrator also followed up test results for samples taken.

People whose circumstances may make them vulnerable

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

Good



- Staff knew how to recognise signs of abuse 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. The practice had a GP partner who was the safeguarding lead, and liaised closely with the safeguarding lead for Lister House surgery, regularly attended meetings and provided their details on the practice's website. All staff had received safeguarding training at a level appropriate to their role.
- Flags were placed on patient records to alert clinicians to patient issues.
- Longer appointments were available where appropriate.
- The reception team were alerted to patients who had been identified as having particular challenges accessing services. The alert on the computer screen told the receptionist of the individual requirements to help patients with an appointment.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice held a register for patients with a learning disability and had engaged with Derbyshire NHS Foundation Trust and Derby Teaching Hospitals to support patients. Care

Summary of findings

plans were used that were user friendly and easy to read. Appointment invitations were audited to better understand reasons for DNAs. The practice offered longer appointments for patients with a learning disability.

- The provider recently ran a substance abuse support event.
- The practice provided information in a non-written form to support those with learning disabilities as well as those who were unable to read.
- Patients had access to Citizens Advice Bureau clinics which were hosted at a nearby site.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

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).

- The provider employed its own Mental Health Nurse and Community Support Worker who provided counselling and signposting advice for patients from this practice.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia and carried out advance care planning for patients with dementia. Risk assessments and care plans were in place for appropriate patients.
- The practice told us they had a dementia diagnosis rate of 70% compared to a CCG average of 59%.
- The provider recently hosted a pilot study for dementia support and ran an event specifically to support dementia patients during May. This was attended by 20 patients and carers which led to a number of referrals to local groups including lunch groups and music groups.
- The most recently published data from 2014/15 showed that 77% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the CCG and national averages which were 85% and 84% respectively. This data referred to the performance of the previous provider. Dr Moss and Partners took over the practice in January 2016.
- The practice supplied data which showed that they had completed face to face assessments for 37% of patients who

Good



Summary of findings

had a diagnosis of dementia for the current year but had recently taken on an additional 23 patients from a local care home and had planned to complete those outstanding within the next five months.

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The provider had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results were mixed when compared with local and national averages. 366 survey forms were distributed and 116 were returned. This represented a 32% response rate.

- 76% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 85% and the national average of 85%.
- 76% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and the national average of 85%.
- 70% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and the national average of 78%.
- 46% of patients found it easy to get through to this practice by phone compared to the CCG average of 72% and the national average of 73%.

Some of this data may have referred to the performance of the previous provider. Dr Moss and Partners took over the practice in January 2016.

The partners conducted a patient survey six months after taking over the management of the practice. Results showed that, since the takeover;

- 54% of patients found it easier to make an appointment
- 66% of patients were happy with the services provided by the GP
- 42% of patients found it easier to get through to the practice by phone

- 84% of patients would be happy for Dr Moss and partners to continue to provide services
- The partners acknowledged that there was further work to do on improving telephone access.

The provider had identified when they took on the caretaker contract that there were existing issues regarding phone access to the practice, and immediately implemented a plan to resolve this.

It is acknowledged that improvements to patients survey results may be seen over time

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards which were all positive about the standard of care received. Patients referred to staff as being kind, professional and respectful. Many commented that there had been improvements generally within the last year.

However, several patients included a comment that related to difficulty in getting an appointment when they wanted one and that it could sometimes be challenging to get through on the telephone to make an appointment.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought most staff were approachable, committed and caring. They told us that their experience of visiting the surgery was generally good, although appointments sometimes ran a little late. Comments also referred to improvements in general that had been made during the last 9 months.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The partners should review the need for contingency plans to cover absences so that administration staff are able to complete administration processes effectively.

- The partners should consider incorporating sufficient detail in their safeguarding meeting minutes to enable staff to access relevant information when they have not attended the meeting'

Lister House at Chellaston

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 adviser, a second CQC inspector, and an Expert by Experience.

Background to Lister House at Chellaston

Lister House at Chellaston was formally known as Meadowfields Practice. Since January 2016, It has been managed in a caretaker role by Dr Moss and Partners, who are the providers for Lister House surgery. Dr Moss and Partners also provided caretaker services to Coleman Street surgery and incorporated both locations in its governance, financing and staffing structures, which has enabled GPs, nurses and some non-clinical staff to work across all four provider sites. On the day of our inspection, the provider was waiting for a formal decision to be made on whether the caretaking arrangement was to become permanent. This was confirmed shortly after our inspection.

Clinicians and most staff work across all four sites managed by the providers, Dr Moss and Partners. The current combined patient list size is 34,620. The patient population is diverse, ranging from the inner city to more affluent suburban areas. All 4 premises are purpose built and accessible for patients with disabilities.

Additional services provided by Dr Moss and Partners at Lister house surgery and branches are available to patients at this practice.

For all four sites, patient access is governed by a clinically led triage protocol, that ensures patients are seen by clinicians appropriate to their condition, and that any patient that needs to talk to or see a clinician will do so on the same day.

Lister House at Chellaston is located in purpose built premises in Chellaston, Southern Derbyshire. Facilities are on two floors including consulting and treatment rooms. The practice has car parking including parking for patients with a disability.

The level of deprivation within the practice population is below the national average with the practice falling into the 4th most deprived decile. The level of deprivation affecting children and older people is significantly higher than the CCG and national average. The practice has higher than average numbers of children and working age patients. Numbers of older people are below average.

The clinical team is comprised of seven GP partners (two female, five male), and nine salaried GPs, (eight female and one male) three Advanced Nurse Practitioners (ANP), 10 practice nurses and three healthcare assistants. The clinical team is supported by a practice business manager, assistant practice manager, community attached staff, two care coordinators, reception and administrative staff. The team is also supported by a head of quality and practice improvements and a special projects administrator, whose roles are dedicated to improving efficiency, safety and the collection of evidence.

The provider also employs a mental health nurse and a community support worker, and an ANP to coordinate care for care homes aligned to the practice.

The practice is a teaching practice for medical students and nursing students.

Detailed findings

The surgery is open from 8am to 6.30pm on Monday to Friday. Consulting times vary but are usually from 8am to 6.30pm during the day with urgent appointments each day from 9am to 12pm and 3.30pm to 6.30pm.

The practice has opted out of providing out-of-hours services to its own patients. This service is provided by Derbyshire Health United (DHU) and is accessed via 111.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 October 2016. During our visit we:

- Spoke with a range of staff (GPs, nurses, attached staff, practice manager, reception and administration staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members

- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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).

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 had systems and processes in place to enable staff to report and record incidents and significant events.

- Staff informed one of the managers of any incidents and completed a form detailing the events. Copies of the forms were available on the practice's computer system. All staff were aware of the significant event process and able to describe their roles in incident reporting (reporting, recording and investigation).
- The incident recording system supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- When things went wrong with care and treatment, patients were informed of what had happened and offered support, information and an apology. Affected patients were also told about actions taken to improve processes to prevent the same thing happening again. For example; when there was a delay in responding to an urgent referral, the practice created an automatic alert to the administration team whenever an urgent referral was initiated that required an appointment within two weeks.
- Incidents and significant events were discussed at the weekly practice meetings and summarised in a quarterly staff newsletter and learning was disseminated across different staffing groups.

We reviewed safety records, incident reports, and safety alerts reported in the previous twelve months and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example; when patients were contacted regarding a safety alert relating to their blood glucose measuring strips, the actions taken were recorded in the patients record.

Overview of safety systems and processes

Systems, processes and practices were in place at the practice to help keep patients safe and safeguarded from abuse. These included:

- Effective arrangements were in place to safeguard children and vulnerable adults from abuse which

reflected local requirements and relevant legislation. Policies were accessible to all staff and identified who staff should contact if they were concerned about a patient's welfare. There was a lead GP for child and adult safeguarding and staff were aware of who this was. The lead GP liaised closely with the safeguarding lead for Lister House surgery and held quarterly meetings with GPs and relevant practice staff, health visitors and school nurses to discuss children at risk. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level 3. Lead staff were committed to ensuring their knowledge was up to date. The patient records we looked at showed that comprehensive records were maintained and were accessible to community staff involved in their care. However, meeting minutes for their safeguarding meetings were quite brief and lacking in detail

- Patients were advised through notices in the practice that they could request a chaperone if required. Nursing and some reception staff acted as chaperones. All staff who acted as chaperones had been provided with training for the role, however they had not all received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had conducted a risk assessment for those staff who had not received a DBS check.
- During our inspection we observed the practice to be clean and tidy and this aligned with the views of patients. A practice nurse was the lead for infection prevention and control (IPC) within the practice, with support and governance advice from the Head of Quality and the Special Projects Administrator. There were mechanisms in place to maintain high standards of cleanliness and hygiene. The practice had effective communication with the cleaning staff, which included employed as well as contract cleaners to clean the practice. Effective cleaning schedules were in place which detailed cleaning to be undertaken daily and weekly for all areas of the practice. There were infection control protocols and policies in place and staff had received up to date training. Infection control audits were undertaken annually, the most recent being June 2016. This was part of a three day comprehensive audit

Are services safe?

that involved each of the four sites. Improvements that were actioned at this practice were; soap dispensers were upgraded, and window sills were decluttered in some areas. Reminders about infection prevention and control measures were shared with staff in the quarterly staff newsletter.

- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Patients were monitored and blood results checked prior to issuing repeat prescriptions. Action was taken when updates to medicines were recommended by the Medicines and Healthcare Products Regulatory Agency (MHRA) and patients were recalled to review their medicines when appropriate.
- There was effective management and procedures for ensuring vaccination and emergency medicines were in date and stored appropriately. The practice carried out regular medicines audits, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- We reviewed five personnel files for clinical and non-clinical staff and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place to manage and monitor risks to patient and staff safety. The practice had up to date fire risk assessments and carried out fire drills. There was a fire alarm test conducted on the day of our inspection. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as legionella. We saw that appropriate action was to act upon any identified risks to ensure these were mitigated.

- Arrangements were in place to plan and monitor staffing levels and the mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The partners told us that staff were able to cover each other across all four sites. However, on the day we visited, some reception and administration staff told us that there had been difficulties in providing cover for recent long term sickness which had led to delays in completing some tasks and processing some information. We found that there had been a delay of more than four weeks in processing a hospital letter for a child. This was actioned immediately. Reception and administration staff told us that letters are usually processed quickly and the standard procedure is to make three contacts with the parent including two telephone calls and a standard letter to encourage them to rebook an appointment to attend.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Staff told us about a recent example where a patient collapsed and all attending staff were aware of what to do.
- Staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were accessible to staff and all staff knew of their location. All the medicines we checked were in date.
- 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 suppliers. In addition to copies held within the practice, copies were also kept off site by key members of staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff assessed the needs of patients and delivered care in line with relevant evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and local guidelines.

- Systems were in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and local guidelines electronically. Relevant updates to these were discussed in clinical meetings and through educational sessions.
- Staff completed regular training which supported their knowledge about changes and updates to guidelines.
- The practice monitored that these guidelines were followed through risk assessments, audits and checks of patient records.

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 were from 2014/15 and were 98% of the total points available.

Some of this data may have referred to the performance of the previous provider. Dr Moss and Partners took over the practice in January 2016.

The practice was not an outlier in 2014/15 for any QOF or other national clinical targets. Data showed;

- Performance for diabetes related indicators was similar to the CCG and national averages. For example; the percentage of patients on the diabetes register with a record of having had a foot examination in the preceding 12 months was 89%. This was the same as the CCG average and 1% better than the national average.
- Performance for mental health related indicators was broadly similar to the CCG and national averages. For example; the percentage of patients with a complex mental health condition who had a comprehensive care plan recorded in the preceding 12 months was 78%. This

was significantly lower than CCG and national averages. (91% and 81%) However, the practice's exception reporting rate for this indicator was just 2% which was significantly better/lower than both the CCG and national averages, which were 21% and 13% respectively.

The practice supplied data to show they had achieved 481.5 out of 545 points for 2015/16 which meant that their overall achievement was 88.35%. This had been taken from the practice's 'How am I driving' data which had not yet been verified or published.

The practice told us that a nurse who managed chronic diseases had identified an issue in their recall system for new patients who had a diagnosis of diabetes. The coding error had meant that some patients had not received an invitation to attend for an annual review. This was rectified at the time and affected patients were informed and reviewed. A system has since been implemented whereby a dedicated administrator checked the coding for every new patient every two months.

The practice were anticipating improved performance for all QOF indicators in the forthcoming year. They had reviewed their processes for reviewing patients diagnosed with diabetes within the last year. Patients were first invited for an appointment with a healthcare assistant (HCA) for blood checks, blood pressure check, foot check and other basic measurements. A follow up appointment was made with a registered nurse of the patients choice. Test results were sent to the patient by letter prior to this appointment. The impact of this was that patients were kept informed, were encouraged to keep their shorter appointments, and the time spent with a registered nurse was reduced from 30 minutes to 20 minutes. This enable the practice to offer more appointments.

Effective arrangements were in place to ensure patients were recalled for reviews of their long term conditions and medication. Patients were recalled at least three times for their reviews using a variety of contact methods including letters, telephone calls, and messages on the patient record. The variety of contact methods reduced the risk of patients not receiving a reminder and there was a dedicated nurse administrator who managed and monitored DNA letters, and liaised closely with nurse leads.

There was evidence of quality improvement including clinical audit.

Are services effective?

(for example, treatment is effective)

- There had been a number of clinical audits undertaken in the last two years. These covered areas relevant to the practice's needs, areas for development, and to ensure latest guidance was being followed and highlight changes which could be made to practice.
- We reviewed several that had been completed over two years, where the improvements made were implemented and monitored. For example; an audit of minor surgery procedures showed that samples were sent for histology testing appropriately and reasons for any not tested were appropriately recorded in the patient record.
- The practice undertook prescribing and medicines audits in conjunction with the CCG pharmacist when updates were received.
- Referrals audits were completed by the practice project administrator to check that agreed protocols and guidelines were being adhered to. For example; two week waits, urgent referrals and outliers.

Effective staffing

We saw that staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had comprehensive, role specific, induction programmes for newly appointed clinical and non-clinical staff. These covered areas such health and safety, IT, fire safety, infection control and confidentiality. Staff were well supported during their induction and probation periods with opportunities to shadow colleagues and regular reviews with their line manager.
- Daily mentor and debrief sessions were in place to support GP registrars in their roles.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. Staff were encouraged and supported to develop in their roles to support the practice and to meet the needs of their patients. Staff were also supported to undertake training to broaden the scope of their roles. For example; mentorship training for nurses, and diploma and degree level clinical training for chronic disease management and minor illness. The practice provided NVQs and apprenticeships for non-clinical staff.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.

Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice nurse meetings.

- All staff had received an appraisal within the last 12 months, and their learning needs were identified. Staff had access to training to meet their learning needs and to cover the scope of their work. This included ongoing support, meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. The practice held some educational meetings which were accessible to clinicians. Recent topics covered were; care and treatment of glaucoma, osteoporosis and dementia.
- Staff received training that included: safeguarding, fire safety, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

Information needed to plan and deliver care was available to staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results. The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

There was a strong emphasis on multidisciplinary working within the practice. Multidisciplinary meetings with other health and social care professionals held on a regular basis. These included palliative care meetings and safeguarding children and adult meetings.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of their capacity to consent in line with relevant guidance.
- Where a patient's capacity to consent to care or treatment was unclear clinical staff undertook assessments of mental capacity.

Are services effective?

(for example, treatment is effective)

- Consent obtained was recorded in the patient record.

Supporting patients to live healthier lives

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

- Patients receiving end of life care,
- Carers,
- Those at risk of developing a long-term condition
- Patients with a learning disability
- Patients with a mental health issue
- Patients who have difficulty in coping

Patients were signposted to the relevant service through use of information provided in the waiting area and through the care coordinator who was able to refer patients to Livewell, which was a healthy lifestyle service designed for Derbyshire residents registered with a GP. Its programme included helping patients with weight management (including child weight management), smoking cessation and increasing physical activity. The practice also had a nurse 'champion' for this service who also referred patients to this service.

The practice provided data to show that the uptake for the cervical screening programme in the preceding 12 months was 96%. (data for 2015/16 has not been verified or published for this practice). This was significantly higher than the CCG average of 84% and the national average of 83%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability

and they ensured a female sample taker was available. The practice had a dedicated nurse lead and nurse administrator who ensured results were received for all samples sent for the cervical screening programme and followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice provided data to show that the uptake for bowel cancer screening for the preceding 12 months was 57.23%. (data for 2015/16 has not been verified or published for this practice). This was comparable with the CCG average of 60.06% and national average 57.46%. The practice has identified a training awareness programme with NHS England and planned to train a nurse champion in this area in order to increase uptake of bowel cancer screening.

The practice provided data for the preceding 12 months to show that childhood immunisation rates for the vaccinations given were between 77% and 98%. This was comparable to CCG/national averages. (data for 2015/16 has not been verified or published for this practice)

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. The practice had conducted 128 NHS health checks in the preceding 12 months. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed during the inspection that members of staff were polite, friendly and helpful towards patients. Measures were in place within the practice to maintain the privacy and dignity of patients and to ensure they felt at ease. These included:

- Curtains were provided in consulting rooms to maintain dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- The reception area provided sufficient space for patients to wait whilst other patients were speaking to receptionist, however, some conversations could be overheard when the reception area was quiet.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

All of the 23 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients generally said they felt the practice offered an excellent service and staff were helpful, professional, friendly, caring and treated them with dignity and respect.

We spoke with three patients in addition to three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 83% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.

- 79% of patients said the GP gave them enough time compared to the CCG average of 87% 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 96% and the national average of 95%
- 79% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 85% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 77% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%

Some of this data may have referred to the performance of the previous provider. Dr Moss and Partners took over the practice in January 2016.

The partners conducted a patient survey six months after taking over the management of the practice. Results showed that, since the takeover;

- 66% of patients were happy with the services provided by the GP
- 78% of patients felt that the receptionists welcomed them and were helpful

The practice were aware of the need to improve patient satisfaction with regard to helpfulness of receptionists and had implemented a regular quiz. The quiz aimed to improve performance and included relevant subjects such as learning from significant events, telephone guidance and managing prescription queries. They had also implemented a call recording system where calls were assessed and feedback given to the receptionist as part of their ongoing development.

The practice had been taken over by Dr Moss and Partners since January 2016 and whilst we identified areas of significant improvement, it was acknowledged that improvements in patient satisfaction surveys will be reflected over time.

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

Are services caring?

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 from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 80% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%

Some of this data may have referred to the performance of the previous provider. Dr Moss and Partners took over the practice in January 2016.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services 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.
- Information leaflets were available in easy read format.
- Picture leaflets were available for people with a learning difficulty
- Patients were encouraged to contribute to their care plans

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 126 patients as carers (1.2% of the practice list). Written information was available to direct carers to the various avenues of support available to them. This was also included in the welcome pack for new patients. The practice had information displayed in the waiting area and on the practice website to inform carers about the support that was available to them and to encourage them to identify themselves to practice staff.

The practice had hosted a carers cafe which was led by Derbyshire Carers Association. Feedback from the event was very positive and the practice were planning further events. A care coordinator was available to help direct carers to sources of help and advice if needed.

The practice implemented a 'special patient' list so that when patients called who were known to have individual or challenging needs, this was flagged up on the patient record and the agreed protocol was actioned. This sometimes meant that the practice manager or assistant practice manager met with them in a private room to deal with their request, a longer appointment was booked, or that an identified GP or nurse would see them for their appointment.

Staff told us that if families had experienced bereavement, they were contacted by the practice by a telephone call or a visit if appropriate. Information about support available to patients who had experienced bereavement was provided where required. The practice also encouraged bereaved patients to attend an appointment with the mental health nurse who worked full time at the nearby Lister House surgery and held appointments across all sites including this practice. An invitation was routinely sent to bereaved patients about one month after their loss, to speak with the mental health nurse about how they were coping.

Staff told us that they also valued the work of the mental health nurse who provided support for staff as well as patients.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice served a population that was the fourth most deprived on the deprivation scale and much higher than average income deprivation for older people and children than both the CCG and national averages. Because of this, they had reviewed the needs of the patient population and configured their services to meet the needs of their population.

- The practice had developed the team and had employed staff specifically to meet the needs of the patients. For example, a full time mental health nurse and community support worker. They had also recruited an advanced nurse practitioner to work specifically with care homes.
- The provider provided a targeted programme for patients with substance misuse.
- The practice's registration booklet took account of the accessible information standard and asked patients if they had any specific needs, for example; British Sign Language, braille, large print, easy read format, as well as their preferred contact method and other support needed.
- The provider had designed and implemented a triage system for non-clinical staff to use in assisting them to prioritise patients' needs when they called. (This had only just been extended to this practice and staff were still receiving supervision and mentorship when we visited) The prioritisation tool had been commended by the CCG who were liaising with the provider to see whether it could be shared more widely.
- The practice told us that around 4-5% of their practice population received home visits. This included local care homes and patients at a supported living facility.
- The GPs provided regular "ward rounds" to three care homes on specific days. However, an audit on home visit requests showed a significant number of these requests related to patients residing in care homes and fell on days when a ward round was not undertaken. The practice responded to this by recruiting an Advanced Nurse Practitioner (ANP) to lead on supporting patients in care homes. The ANP worked with lead GPs to provide regular ward rounds, plan care, assess patients' needs and was able to diagnose illness and prescribe medicines. The practice were planning to

audit the impact of this role after 12 month, but told us that initial information showed that it had resulted in a reduction in the number of home visits made by GPs and increase in satisfaction from care home managers and residents with improved continuity of care. There was also an initial cost saving identified following medicines reviews made by the ANP.

- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The provider employed its own Mental Health Nurse and Community Support Worker who provided counselling and signposting advice for patients. This allowed for significantly longer appointments than GPs were able to offer and feedback from patients showed talking to these staff members had a positive impact on their mental well-being. The practice told us that patients often said how much they valued the service. Comments from the CQC comments cards aligned with this view. Staff we spoke with on the day also told us that they were sometimes supported by this service at work during times of personal difficulty. Feedback from a mental health recovery worker at Rethink Derby Steps showed patients were referred timely to their service which enabled early intervention and emotional support to be provided. This minimised the need to refer patients to secondary care mental health services.
- The reception team operated a 'special' patients list using patient plans. These were patients that had been identified as having particular challenges accessing services. Arrangements were in place to assist where possible.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice were aware of caring for vulnerable groups in their population.
- The Practice worked closely with the CCG Learning Disability facilitator to create a register. Care plans were used that were user friendly and easy to read. Appointment invitations were audited to better understand reasons for DNAs. The practice offered longer appointments for patients with a learning disability.



Are services responsive to people's needs?

(for example, to feedback?)

- A comprehensive musculoskeletal triage and treatment service was provided at one of the local sites managed by the provider, Dr Moss and Partners. The GP led community musculoskeletal assessment and treatment service was accessible to patients registered with 26 local practices. Two of the GPs took a lead role with support from another local GP. The impact of this service provision included a 50% to 60% reduction in orthopaedic referrals to secondary care services.
- The provider hosted consultant led 'first outpatient spinal clinics' operated by Royal Derby Hospital at one of the sites. (Lister House surgery) This enabled care to be more accessible for patients and allowed a closer working relationship between practice GPs and the consultants
- The practice hosted a weekly health visiting clinic that was extended to children who were registered with other local practices as well as this one and provided information on their website which signposted parents to a number of support services.
- A comprehensive immunisation and follow up immunisation program was in place which was managed by a dedicated administrator. The programme included a monthly checking process and up to two letters were sent by recorded delivery to parents where children had not attended for vaccination. The nurse lead for immunisations followed this up by contacting parents by telephone to discuss reasons for not attending and made a follow up appointment. If it was not possible to make telephone contact then the lead contacted the health visitor and an alert was placed on the child's record.
- The practice operated a comprehensive recall system to ensure patients' conditions were appropriately monitored. This was managed by a dedicated administrator.
- The practice provided anticipatory drugs for appropriate patients diagnosed with chronic obstructive airways disease (COPD) to reduce incidences of exacerbation.
- The practice provided a comprehensive travel vaccination service, and was a designated yellow fever vaccination centre.
- Appointments were available on the day for children and were given a high priority in the triage protocol.
- The provider provided 'step down beds' in a local care facility for short term intermediate care to enable early discharge from hospital. This was funded by the CCG. Patients were discharged from hospital to the care

home and assessed by a GP or Care Home Nurse Practitioner and cared for until they were well enough to go back to their own homes. This was typically short term, around two weeks. The impact of this scheme is that patients were discharged from hospital earlier, which reduced the cost burden for the CCG, and provided an environment thought to be more suitable for a recovering patient.

- The in-house phlebotomy service encouraged compliance for blood tests for people who found it difficult to travel to hospital.
- The practice hosted Citizens Advice Bureau clinics and Citizens Advice Bureau Legal Services clinics.
- There were disabled facilities, a hearing loop and translation services available.
- The practice were planning a support event for new mothers and parents to be.

Access to the service

The practice was open between 7am and 7pm Monday to Friday. Appointments were from 8am to 12pm and 12.30pm to 6.30pm daily. Extended hours appointments were offered on Wednesday mornings from 7am to 8am. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were always available for people that needed them.

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

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and the national average of 78%.
- 46% of patients said they could get through easily to the practice by phone compared to the CCG average of 76% and the national average of 73%.

Some of this data may have referred to the performance of the previous provider. Dr Moss and Partners took over the practice in January 2016.

The partners conducted a patient survey six months after taking over the management of the practice. Results showed that, since the takeover;

- 54% of patients found it easier to make an appointment
- 42% of patients found it easier to get through to the practice by phone



Are services responsive to people's needs?

(for example, to feedback?)

The partners acknowledged that there was further work to do on improving telephone access

On the day of inspection, three patients commented on difficulty in getting an appointment via telephone during the morning rush hour, and some patients commented that there had been an improvement at the practice generally during the last 10 months.

The practice was aware of these results and had implemented a number of changes to try and improve access. The practice had a system in place to assess the urgency of the need for medical attention and whether a home visit was clinically necessary.

This was managed by a triage system that was operated by non-clinical staff who had received training and support to use a clinical assessment prioritisation tool which had been designed in-house using a set of clinical algorithms. The prioritisation tool was designed by clinician and regularly updated following feedback from staff (users) and patients.

The call centre at Lister House at Chellaston handled calls for an appointment at this practice and Coleman Street surgery. Symptoms were prioritised according to the clinical algorithm and patients were given an urgent appointment according to their clinical need, given a time slot for a GP to call them back, provided with a time slot for a home visit, directed to a receptionist for a routine appointment, or directed to another health professional, for example; a dentist.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

People told us on the day of the inspection that they were able to get appointments when they needed them. Some of the comments cards told us that the telephone system and appointments system had improved recently.

Listening and learning from concerns and complaints

The practice systems in place to handle complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system including posters.
- Staff we spoke with were aware of the complaints procedures within the practice and told us they would direct patients to practice manager if required.

The practice had logged 36 complaints and concerns in the last 12 months including verbal complaints. We reviewed a range of complaints and we found they were dealt with in a timely manner in accordance with the practice's policy on handling complaints. The practice provided people with explanations and apologies where appropriate as well as informing them about learning identified as a result of the complaint.

Complaints were discussed at practice meetings. This enabled the practice to identify any themes or trends and all relevant staff were encouraged to attend. Lessons learned from complaints and concerns and from trend analysis were used to improve the quality of care staff were informed of outcomes.

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 provider's mission statement was clearly advertised for patients on the practice website and waiting areas within the practice. It stated, "Dr Moss and Partners aim to provide the highest quality healthcare to our patients. We will serve our local communities by providing an excellent standard of comprehensive, professional healthcare to all our patients. Our well trained multidisciplinary staff are caring, organised and responsive to our patient's needs. They are continually striving to improve our service and work in partnership with our patients".

Staff we spoke with knew and understood the values and vision, and there was a high sense of ownership. Values described by the staff included;

- patient centred care,
- continuity of care that allows patients to have a good relationship with staff,
- working together with a balanced clinical team of GPs, ANPs and nurses with specialist skills to support the needs of the varied population,
- supportive management style that is team orientated and staff value each other.

The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable. For example, the provider Dr Moss and Partners have been managing two practices (Lister house at Chellaston and Lister house at Coleman) on a 'caretaker' basis since January 2016. Our inspection of this practice showed significant improvements had been made to patient care and staff welfare as a result of their input.

The business plans included;

- A resourcing and recruitment plan
- A re-structuring of staff roles across the four sites.
- Collaborative working
- Further development of patient services
- A commitment to developing staff, including use of apprenticeships and NVQs.
- Flexible working across roles

- Working with student nurses, medical students and local sixth form students.

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 that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- The practice engaged with their CCG, and attended locality meetings and the practice managers' forum and nurse forum to work collaboratively and share best practice.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners and management within the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Clinical and non-clinical staff had a wide range of skills and experience. Staff told us they prioritised safe, high quality and compassionate care. Staff told us the partners and management were approachable and always took the time to listen to all members of staff.

There was a rolling programme of weekly meetings held within the practice to communicate and facilitate improvement across all staffing groups. This included meetings for GPs, the management team and clinical staff. The provider also arranged 'away' days for staff, providing external facilitators, guest speakers and GP presentations. Periodic meetings were held for reception staff with regular updates communicated via notifications, emails and a staff bulletin by senior management.

Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team

Are services well-led?

Good 

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

meetings and felt confident and supported in doing so. The provider arranged and / or funded social activities and meals out for staff. The provider also arranged 'away' days for staff, providing external facilitators, guest speakers and GP presentations.

All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Staff told us they would not hesitate to share ideas for improvements with the management or the GPs within the practice.

The practice were keen to promote the safe culture they had built and encouraged proactive communication provided in a number of ways where staff could receive information about changes, updates and news about the practice. For example;

- there was an open staff forum each Friday where staff could give feedback,
- there was a staff bulletin issued to provide updates, news and results of surveys and audits. The bulletin also provided staff with an overview of the learning shared following SEA reviews, and served as a reminder to staff about any changes to practice that had been communicated in recent staff meetings.

Some of the GPs and management staff held external roles which included radiology CIG lead, member of the GP task force and planned care lead for Derby commissioning Network Locality (DCN). DCN is made up of 12 practices covering a population of approximately 145,000. A GP was also the planned care lead for Southern Derbyshire CCG. The practice actively promoted patient and GP education and hosted a community musculoskeletal service which was aligned with the 2014/2015 DCN priorities. The strategic roles of staff enabled them to share best practice with the wider team and improve the quality of care for patients.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people support, information and apologies where appropriate.
- The practice kept records of verbal interactions as well as written correspondence.

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

Dr Moss and Partners had provided leadership, management and financial support to this practice in a caretaker role since January 2016 and had made significant improvements during this time. They told us that all of the partners were highly committed to making further improvements for the benefit of patients 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 the patient participation group (PPG) and through surveys and complaints received. The PPG met every few months, carried out patient surveys and made suggestions for improvements to the practice management team.
- The practice had gathered feedback from staff through the Friday feedback sessions an annual staff survey, through staff away days and generally through staff meetings, appraisals and discussion. 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.

All staff interviewed spoke positively about the improved culture within the practice following the takeover by Dr Moss and partners. They told us that morale had improved due to increased staffing which has reduced workload pressures and roles and responsibilities have been clarified. Staff also felt management were approachable, there was an open culture where staff could raise issues with confidence they would be supported by management and receive feedback. For example, the practice ran 'Friday feedback' sessions where all staff were encouraged to provide views on service and feedback was shared with GP partners to inform service development. A recent away day for all staff included fun activities and team bonding.

Continuous improvement

Are services well-led?

Good 

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

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice embraced opportunities to develop the practice and improve patient care. For example;

- They encouraged medical students and student nurses to work under supervision at the practice to enable GPs and nurses to utilise their mentorship skills and to bring additional skills to the practice.
- They encouraged work placements for sixth form students to encourage young people to consider their career options.
- They enabled one of their practice nurses to work with the CCG as part of a task force to re-design a community based diabetes service.
- They engaged with a local practice and an independent healthcare as providers of a training hub for medical students, student nurses, and some non-clinical staff to support clinical placements.

- They engaged with NHS England in a pilot project to provide clinical support and mentorship for one Independent Prescribing Pharmacist to work at the practice for three days each week to work with patients, review medicines and process prescriptions.

The practice also undertook Quality Improvement projects. For example;

- Implementation of a Single Screen approach to sharing data with a wider clinical and non-clinical team across all sites. This has enabled a more efficient sharing of work load allowing patient data to be shared regardless of the practice code. The providers have told us that the project has facilitated an improvement in resilience and improved patient outcomes.
- Implementation of an interactive Messaging system (MJOG) which is a two way patient communication system.
- Trialling the new Southern Derbyshire CCG Infection Prevention and Control Audit gold standard.

The impact of these initiatives on patient care had yet to be determined and evidenced.