

Dr Moss and Partners

Quality Report

Lister House Surgery
207 St Thomas Road
Derby
Derbyshire
DE23 8RJ

Tel: 01332 271212

Website: www.listerhousesurgery.co.uk

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

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 on 13 October 2016. Overall the practice is rated as good.

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

- The practice had a clear vision which had quality and safety as its top priority. However, the arrangements relating to the safeguarding of children and vulnerable adults required improvement to ensure effective systems were established and operated effectively to protect them from abuse. In response to our initial findings, the practice had taken immediate action and made significant changes to address concerns relating to record keeping, coding of patient records, information sharing and identification of vulnerable adults at risk of abuse.
- The practice received safety alerts issued by external agencies. However, the system in place for acting upon alerts was not embedded to ensure that staff had taken appropriate action in response to Medicines and Healthcare products Regulatory Agency (MHRA) alerts.
- There was an effective system in place for managing significant events. Learning was shared widely across all staffing groups.
- Most risks to patients were assessed and well managed including procedures for managing medical emergencies and health and safety.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. They had the skills, knowledge and experience to deliver high quality care and treatment. Effective systems were in place to ensure staff were supported with induction, training, supervision and appraisal.

Summary of findings

- Clinical audits were used to review patient care and improve services.
- There was a systematic approach to working effectively as a whole practice team, involving patients and other stakeholders to deliver effective and integrated care for patients. This approach had resulted in a reduction in unplanned hospital admissions and attendance at accident and emergency.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The clinical team had a wide range of skills which were tailored to meet the needs of patients. This included a mental health nurse to assess and support patients experiencing poor mental health and or bereavement, three advanced nurse practitioners who took a lead in managing the minor illness clinics, a care home specialist nurse, a pharmacist and a community support worker.
- The practice had around 4000 patients from the Romani Slovak community. In response to this, an interpreter was employed five days a week to cater for their communication needs.
- The provider had developed and implemented a “medical assessment triage protocol” for use by non-clinical staff to direct patients to the most appropriate clinician in a timely manner without them making a clinical decision. Symptoms were prioritised according to the guidance and patients were given an urgent appointment according to their clinical need. We received positive feedback from both staff and patients regarding the triage system. The protocol had been commended by the clinical commissioning group (CCG) who were liaising with the provider to see whether it could be shared more widely.
- Most patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well-equipped to meet the needs of patients.
- Improvements were made to the quality of care as a result of complaints, concerns and feedback from patients and the patient participation group.
- The strategy to deliver the practice vision and governance arrangements were regularly reviewed and discussed with staff.
- 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.
- 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 East Midlands and the CCG 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.

We saw several areas of outstanding practice:

The practice was highly responsive to providing services that meet the needs of patients. For example,

- The practice hosted and facilitated community based services which enabled care to be provided closer to home for patients. For example, since 2010, the practice has hosted a GP led community musculoskeletal assessment and treatment service which is accessible to patients registered with 26 local practices. Two of the practice GPs took a lead role in managing this service 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 a strong emphasis on multi-disciplinary working within the practice. The practice worked in collaboration with two local practices and health professionals (from Derbyshire community health services) to identify the support needs and improve the management of patients who frequently accessed health and social care services with a view to reducing admissions. The practices received

Summary of findings

funding to support a dedicated GP resource to lead the weekly collaborative meetings with the community team where complex cases were discussed and plans agreed. The practice had evaluated the benefits of this project for the period November 2015 to July 2016 and quantitative data showed positive outcomes were achieved for patients and the practice. The findings showed: a reduction of acute GP visits by 38%; a reduction of GP appointments by 29%; a reduction of nurse appointments by 34% and an overall reduction in accident and emergency admissions with significant cost savings for the CCG.

- In addition, records reviewed showed a residential care home was requesting 13 to 16 GP visits each month for 10 residents registered with the practice. Initially, joint visits were undertaken by the GP lead and attached community matron to ensure patients received a comprehensive and holistic review of their care needs in their home. The community matron now visits the care home on a weekly basis to review the patients' health needs reducing the number of home visits made by GPs.
- The care of older people was prioritised in response to findings of a home visit audit. A care home specialist nurse was employed to coordinate the care of residents living in care homes. They worked closely with care home staff and practice GPs to achieve positive outcomes for patients. Within a six week period, the nurse had completed the following interventions: 62 medicine reviews; 40 dementia annual reviews, 19 diabetes reviews and 59 new care plans had been put in place for example. The visits

undertaken by the nurse meant 67 face to face GP visits were not required and there had been significant cost saving with regards to improved prescribing of nutritional supplement drinks. Records reviewed (patient satisfaction questionnaires) showed patients were positive about the service received. They felt their health and care needs were fully met and excellent care was provided.

The areas where the provider must make improvement are:

- Ensure improvements made to safeguarding arrangements operate effectively and are embedded within the practice to protect children and vulnerable adults from abuse. Specifically, record keeping, coding of patient records, information sharing and identification and communication with relevant agencies.

The areas where the provider should make improvement are:

- Continue to proactively identify carers within the practice.
- Strengthen the systems for managing patient safety alerts to ensure established and effective systems are in place to keep patients safe. This includes maintaining records to evidence the receipt of and actions taken in respect of Medicines Health and Regulatory Authority (MHRA) alerts.

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 requires improvement for providing safe services.

Requires improvement



- There was an effective system in place for reporting, recording and reviewing significant events. Lessons were shared to ensure appropriate action was taken to improve safety within the practice.
- Following our inspection, the practice provided additional evidence to demonstrate the immediate action taken to ensure patient safety information issued by external agencies was acted upon. This included alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- The practice had safeguarding arrangements in place but these required strengthening to ensure patients were kept safe. In particular, record keeping, coding of patient records, information sharing and identification of vulnerable adults at risk of abuse. Following our inspection we were provided with additional evidence to demonstrate significant improvements and changes had been made to address the identified concerns. Written assurances were also received to confirm all concerns were fully addressed as at 21 November 2016. This will be reviewed at the re-inspection of the practice.
- Medicines including vaccines were stored safely and systems were in place to monitor their prescribing and use.
- Appropriate steps were taken to ensure suitably qualified and experienced staff were employed and that staffing levels were sufficient to meet patient needs.
- Risks related to infection control and health and safety were assessed and well-managed including procedures for fire safety and legionella.

Are services effective?

The practice is rated as good for providing effective services.

Good



- The 2015/16 quality and outcomes framework (QOF) data showed most patient outcomes were at or above local and national averages. The practice had achieved 96.4% QOF points compared to the local average of 97.2% and the national average of 95.3%.
- Clinical audits were used to review patient care and drive quality improvement.

Summary of findings

- Staff assessed needs and delivered care in line with National Institute for Health and Care Excellence (NICE) and local guidelines.
- Staff had the skills, knowledge and experience to enable them to deliver effective care and treatment. The practice employed a good skill mix of clinicians including GPs, advanced nurse practitioners, a mental health nurse and a pharmacist.
- Staff were supported with an induction, training and appraisals including personal development plans.
- Staff worked with other health and social care teams to understand and meet the range and complexity of patients' needs. This included weekly multi-disciplinary meetings to review the care needs of vulnerable patients, those at risk of hospital admission and patients receiving end of life care. Care plans were routinely reviewed and updated.

Are services caring?

The practice is rated as good for providing caring services.

- Feedback from most patients and stakeholders was positive about the way staff treated people. Patients felt cared for, supported and treated with dignity, respect and kindness during their interactions with staff.
- Most patients felt involved in decisions about their care and treatment and this included having access to an interpreter when needed.
- Data from the national GP patient survey showed patients rated the practice in line with or marginally above local and national averages for several aspects of care. For example, 95% of patients found the receptionists helpful compared to the CCG average of 88% and the national average of 87%.
- Information for patients about the services available was easy to understand and accessible in different formats. This included easy read pictorial format and other languages.
- Collaborative working took place between the patient participation group, practice staff and other stakeholders to facilitate support for patients to cope emotionally with their care and treatment. Although the practice had identified 0.8% of its patients as carers, they hosted a dementia café and regular carer events to help direct patients to sources of help and advice if needed.
- An invitation was sent to bereaved patients about one month after their loss, to speak with the mental health nurse about how they were coping.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

- The practice worked in collaboration with two local practices and Derbyshire community health services to deliver integrated and coordinated care; with a view to reducing hospital admission and attendances. Data reviewed and feedback from stakeholders showed positive outcomes were achieved for patients including residents living in care homes. The impact of this project included the reduction on acute GP visits by 38%; a reduction of GP appointments by 29%; a reduction of nurse appointments by 34% and an overall reduction in accident and emergency admissions.
- The skill mix of staff had been tailored to meet the needs and services offered to patients. For example, the practice employed a specialist nurse who led on the management of care homes with support from the GPs, a mental health nurse and community support worker.
- The practice offered community services which provided patients with care that was closer to home and reduced the burden on hospital services. This included a GP led community musculoskeletal assessment clinic which had resulted in at least 50% reduction in orthopaedic referrals to secondary care services and a consultant led first outpatient spinal clinic operated by Royal Derby Hospital.
- The provider had developed and implemented a step by step triage protocol for use by non-clinical staff. The protocol enabled staff to direct patients to the most appropriate clinician in a timely manner without them making a clinical decision.
- The citizens' advice bureau offered on-site appointments for patients at the practice.
- The practice had a population of about 4000 patients from the Romani Slovak community. In response to this, an interpreter was employed five days a week to cater for their communication needs.
- Most patients said they found it easy to make an appointment and valued the continuity of care received. This was reinforced by the national GP patient survey data which showed patient satisfaction with accessing care and treatment was rated in line with or above local and national averages: 73% of patients described their experience of making an appointment as good compared to the local average of 72% and the national average of 73%.

Outstanding



Summary of findings

- The practice was located in purpose-built premises and was well equipped to meet the needs of patients including people with disabilities and impairments.
- Information about how to complain was available and easy to understand. Records reviewed showed the practice responded in a timely manner to complaints and learning was shared with staff.

Are services well-led?

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

Good



- The practice had a clear vision with quality and safety as its top priority. However, the systems and processes in place for managing safety alerts and safeguarding children and vulnerable adults did not always operate effectively at the time of inspection.
- Following our inspection, the provider submitted evidence to demonstrate improvements had been made, however this required embedding to ensure changes were sustained.
- The business development plans and strategy to deliver the vision had been produced with stakeholders and was regularly reviewed and discussed with staff. This included a commitment to providing positive outcomes for patients and staff at all four GP premises managed by the provider (Dr Moss and Partners).
- A systematic approach was taken to collaborative working with other stakeholders to improve patient care, tackle health inequalities and obtain best value for money. This included being active members of Derby commissioning network .
- There was a clear leadership structure in place and staff felt respected, valued and supported. High standards were promoted and owned by practice staff, and teams worked together across all roles.
- The practice had a well engaged patient participation group (PPG) which influenced practice development. This also included patient education and fundraising activities.
- 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 Midlands and the clinical commissioning group (CCG) in developing the training and qualifications for advanced nurse practitioners and advanced care practitioners in Southern Derbyshire; taking part in CCG pilot projects and the 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



- Patients aged 75 years and over had a named GP and were offered vaccinations in line with national guidance.
- Older patients at risk of admission to hospital, living with dementia and / or frail were discussed at multi-disciplinary meetings hosted by the practice. Care plans were put in place for patients with complex needs.
- Feedback from care homes confirmed the practice team offered proactive and personalised care to meet the needs of older people in its population.
- The GP lead and / or attached community matron carried out care home visits and home visits to people who were housebound as part of a collaborative community services project, to ensure patients received a comprehensive and holistic review of their care needs.
- The practice employed a specialist nurse practitioner who coordinated the care of residents living in care homes with support from the GPs. The nurse carried out regular home visits which ensured continuity of care and also undertook a wide range of health reviews.
- The practice employed a community support worker whose role included signposting patients to appropriate clinical or social care.
- The practice was responsive to the needs of older people and offered urgent appointments for those with enhanced needs.
- Nationally reported data showed patient outcomes for conditions commonly found in older people, including osteoporosis and heart failure were in line with or above local and national averages. Lower values were achieved for rheumatoid arthritis.

People with long term conditions

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

Good



- Nursing staff had lead roles in chronic disease management and regular clinics were held for patients with conditions such as asthma and diabetes.

Summary of findings

- Patients with diabetes could have their insulin treatment initiated at the practice and where appropriate, patients were referred for a six week education programme to equip them with the skills and knowledge to better manage their diabetes.
- Patients with a diagnosis of chronic obstructive pulmonary disease were offered anticipatory medicines to reduce incidences of exacerbation where appropriate.
- An effective recall system was in place to ensure patients were offered a structured annual review to check their health and medicines needs were being met.
- Patients with more complex needs and at risk of hospital admission were identified as a priority. The named GP worked with relevant health and social care professionals to deliver a multidisciplinary package of care.
- The in-house pharmacist carried out medicine reviews supported by the GPs and an in-house phlebotomy service was also provided.

Families, children and young people

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

- We received positive feedback from the midwife and, health visitor about the joint working and multi-disciplinary working with practice staff.
- The practice was proactive in promoting health education in children and young people in a “fun and welcoming environment”. For example, careers in general practice were promoted to sixth form students by offering them work experience and an annual event was facilitated where children from the local primary school visited Lister house surgery.
- A flexible appointment system ensured that children could be seen on the same day when this was indicated. Appointments were available outside of school hours and a telephone triage was utilised to ensure those with urgent requirements were dealt with promptly.
- The practice website included “new parent information” which included guidance on registering the new baby and immunisations. Immunisation rates were broadly in line with local and national averages for most standard childhood immunisations.
- Ante-natal appointments were available with community midwives and post-natal checks were provided within the practice by the nurse and GP.
- Family planning services were provided including the fitting and removal of intrauterine devices (coils).

Good



Summary of findings

- The practice had baby changing facilities and welcomed mothers who breast feed.

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).

- Lister House surgery was open from 7am to 7pm Monday to Friday within which extended hours were provided. Patients were reminded about their appointments via text messages if they had signed up for the service.
- Patients could book GP appointments online and request repeat prescriptions at a time that was convenient for them. The practice also undertook electronic prescribing so that prescriptions could be sent directly to the pharmacy of the patient's choice.
- Telephone consultations were available each day for patients who had difficulty attending the practice due to work or educational commitments.
- The practice was proactive in offering a full range of health promotion and screening service that reflected the needs for this age group. This included healthy lifestyle advice, cancer screening and NHS health checks for patients aged 40-74.
- Health promotion information was available in the waiting room and on the practice website. This included information on minor illnesses and first aid.
- The practice provided travel clinic services and was a registered yellow fever centre.
- Two of the GPs were instrumental in facilitating the community musculoskeletal triage and treatment service from the practice. This service was accessible to patients registered with other practices and was supported by an onsite physiotherapy services. This was an outstanding feature of the practice.

Good



People whose circumstances may make them vulnerable

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

- Staff had received training in how to recognise signs of abuse in vulnerable adults and demonstrated awareness of the appropriate action to take if concerns were noted. However, improvements were required to ensure the practice had identified vulnerable adults within the practice population and effective systems were embedded in respect of information sharing and documentation of safeguarding concerns.

Good



Summary of findings

- The practice had 172 patients on its learning disability register and longer appointments were offered for their health reviews. At the time of inspection, 68 patients (40%) had received an annual health check and a further 21 (12%) patients had appointments planned.
- The reception team maintained a 'special patient list' which included patients that had particular challenges accessing services. For example, people with hearing impairments or from the deaf community, those experiencing poor mental health or at risk of isolation. At the time of inspection about 50 patients had been identified and arrangements were in place to help them access services when needed.
- Homeless people in Derby city could access services at this practice and were signposted to other agencies for support if needed.
- In liaison with other stakeholders, the patient participation group (PPG) and practice had hosted an alcohol and drug awareness drop in session in August 2016 and regular carers events. The practice had identified 0.8% of its practice population as carers.
- Patients and their carers were informed about how to access various support groups and voluntary organisations.
- Translation services were available for patients and this included a practice employed Slovak Romani interpreter to cater for communication needs of about 4000 patients.
- The citizens' advice bureau offered on-site appointments for patients at the practice.
- 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, as well as their preferred contact method and other support needed.
- Clinical staff regularly worked with other health and social 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 2015/16 data showed all (100%) patients diagnosed with dementia had their care reviewed in a face to face meeting compared to the local average of 85% and the national average of 84%. The exception reporting rate for this indicator was 7% which was in line with the local average of 8% and the national average of 7%.

Good



Summary of findings

- The practice team and patient participation group had a good understanding of how to support patients with dementia and their carers. This included hosting a dementia café within the practice, carrying out advanced care planning where appropriate and engaging in the dementia screening pilot in collaboration with specialist nurses. The dementia diagnosis rate was 70% compared to a local average of 59%.
- The 2015/16 data showed 99.3% of patients on the practice's mental health register had received an annual health check compared to the local average of 92.8% and the national average of 88.7%. The exception reporting rate for this indicator was about 10% which was below the local average of 20% and the national average of 13%.
- The practice employed a mental health nurse and a community support worker who were able to see patients for extended appointments and at their home. Follow up appointments were organised where appropriate to establish continuity of care and a supportive service.
- Patients were given advice and / or signposted to various support groups and voluntary organisations for support.
- The practice regularly worked with multi-disciplinary teams and care home providers in the case management of patients experiencing poor mental health including people with dementia. This included following up patients who had attended accident and emergency and participating in a locally commissioned services framework project on psychosis.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published in July 2016. There were 323 survey forms distributed to patients and 94 of these were returned. This represented a return rate of 24% and equated to 1.3% of the registered practice population at both Lister House Surgery and Oakwood medical centre. Most of the results showed the practice was performing above or in line with local and national averages. For example, the three areas the practice did best were as follows:

- 85% of patients found it easy to get through to this surgery by phone compared to a clinical commissioning group (CCG) average of 72% and a national average of 73%.
- 66% of patients with a preferred GP usually get to see or speak to that GP compared to a CCG average of 55% and national average of 59%.
- 78% of patients usually wait 15 minutes or less after their appointment time to be seen compared to a CCG average of 69% and national average of 65%.

The three areas the practice could improve on included:

- 83% of patients said the GP gave them enough time compared to the CCG and national averages of 87%.
- 81% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared to a CCG average of 86% and national average of 85%.
- 88% of patients said the last appointment they got was convenient compared to a CCG average of 93% and national average of 92%.

We spoke with 25 patients including patients whose first language was Slovak Romani or Slovak Romanian via our interpreter. Most patients said they were satisfied with the care provided by the practice and were treated with compassion and respect by staff. Less positive comments related to not always being seen by their preferred doctor and continuity of care not being maintained.

We also spoke with three members of the patient participation group (PPG) who praised the staff highly and gave examples to demonstrate how staff had responded compassionately when they needed help and support.

As part of our inspection we asked for CQC comment cards to be completed by patients. We received 40 comment cards which were all positive about the standard of care received. Seven of the 40 comment cards also contained less positive comments relating to continuity of care, telephone access and availability of appointments. Patients stated they were treated with dignity and respect, felt listened to during their consultations and they received a very good service. Staff were described as approachable, committed and caring. Seven out of 10 comments received from Healthwatch were also positive about the care received.

The practice had carried out a survey in 2015 of which 112 patients had responded. Some of the results showed: 96% of patients found the GPs and nurses polite and considerate; 87% of patients said the GP and nurses involved them in decisions about their care and 69% of patients found it easy to get through to Reception at the practice to get through to the practice by phone.

Areas for improvement

Action the service **MUST** take to improve

- Ensure improvements made to safeguarding arrangements operate effectively and are embedded within the practice to protect children and vulnerable adults from abuse. Specifically, record keeping, coding of patient records, information sharing and identification and communication with relevant agencies.

Action the service **SHOULD** take to improve

- Continue to proactively identify carers within the practice.
- Strengthen the systems for managing patient safety alerts to ensure established and effective systems

Summary of findings

are in place to keep patients safe. This includes maintaining records to evidence the receipt of and actions taken in respect of Medicines Health and Regulatory Authority (MHRA) alerts.

Outstanding practice

The practice was highly responsive to providing services that meet the needs of patients. For example,

- The practice hosted and facilitated community based services which enabled care to be provided closer to home for patients. For example, since 2010, the practice has hosted a GP led community musculoskeletal assessment and treatment service which is accessible to patients registered with 26 local practices. Two of the practice GPs took a lead role in managing this service 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 a strong emphasis on multi-disciplinary working within the practice. The practice worked in collaboration with two local practices and health professionals (Derbyshire community health services) to identify the support needs and improve the management of patients who frequently accessed health and social care services with a view to reducing admissions. The practices received funding to support a dedicated GP resource to lead the weekly collaborative meetings with the community team where complex cases were discussed and plans agreed. The practice had evaluated the benefits of this project for the period November 2015 to July 2016 and quantitative data showed positive outcomes were achieved for patients and the practice. The findings showed: a reduction of acute GP visits by 38%; a reduction of GP appointments by 29%; a reduction of nurse appointments by 34% and an overall reduction in accident and emergency admissions with significant cost savings for the CCG.
- In addition, records reviewed showed a residential care home was requesting 13 to 16 GP visits each month for 10 residents registered with the practice. Initially, joint visits were undertaken by the GP lead and attached community matron to ensure patients received a comprehensive and holistic review of their care needs in their home. The community matron now visits the care home on a weekly basis to review the patients' health needs reducing the number of home visits made by GPs.
- The care of older people was prioritised in response to findings of a home visit audit. A care home specialist nurse was employed to coordinate the care of residents living in care homes. They worked closely with care home staff and practice GPs to achieve positive outcomes for patients. Within a six week period, the nurse had completed the following interventions: 62 medicine reviews; 40 dementia annual reviews, 19 diabetes reviews and 59 new care plans had been put in place for example. The visits undertaken by the nurse meant 67 face to face GP visits were not required and there had been significant cost saving with regards to improved prescribing of nutritional supplement drinks. Records reviewed (patient satisfaction questionnaires) showed patients were positive about the service received. They felt their health and care needs were fully met and excellent care was provided.

Dr Moss and Partners

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 second CQC Inspector, a GP specialist adviser, a practice manager specialist adviser and an interpreter.

Background to Dr Moss and Partners

The provider

Dr Moss and Partners is registered with the Care Quality Commission to carry out regulated activities from the following two locations:

- Dr Moss and Partners also known as Lister House Surgery - 207 St Thomas Road, Derby, Derbyshire, DE23 8RJ. The branch site is Oakwood medical centre which is located at Danebridge Crescent, Derby, DE21 2HT.
- Lister House at Chellaston (Derby, Derbyshire, The branch site is Lister House at Coleman Street, Coleman Street, Allenton, Derby, DE24 8NH.

The provider has a combined patient list of 34 620 with most of the 103 practice staff working across the four GP premises. The clinical team comprises of:

- Seven GP partners (two female and five male), nine salaried GPs (eight female and one male) and a pharmacist.
- Three advanced nurse practitioners including the nursing lead, 10 practice nurses and three healthcare assistants. All of these staff are female.

- A mental health nurse/psychiatric lead (male) and a community support worker (female).

The provider is an established training and teaching practice and accommodates GP registrars (a qualified doctor who is completing training to become a GP) and medical and nursing students. At the time of our inspection there were two GP trainees in post.

The clinical team is supported by:

- A management team comprising of the business practice manager, assistant practice manager, informatics manager, reception manager and an assistant reception manager.
- 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.
- An administrative team comprising of senior receptionists, receptionists, medical secretaries and administrators.
- The accounts, premises and payroll team includes a senior administrator, maintenance lead and housekeepers.

The attached community staff are located onsite and this includes district nursing teams, community matrons, midwives and a care co-ordinator. A pharmacist employed by the clinical commissioning group also provides regular support to the practice.

Dr Moss and partners (“the location”) also known as Lister house surgery

Dr Moss and partners provides primary care medical services patients via a General Medical Services (GMS) contract commissioned by NHS England and NHS Southern Derbyshire Clinical Commissioning Group. Patients

Detailed findings

registered at Lister house surgery or Oakwood medical centre are able to access services from either of the two sites. The combined patient list for the two surgeries was 24 050 at the time of inspection.

Our inspection visit took place at Lister House surgery, which is located in the inner city of Derby.

Services are provided from a purpose-built premise and this includes consulting and treatment rooms located over two floors. The practice age profile comprises higher numbers of patients aged 0 to 54 years and lower numbers of people aged 55 years and over when compared to the local and national averages.

Forty percent (40%) of the registered patient population is of White British background. Lister House surgery includes a high number of patients from over 50 minority ethnic groups and a transient population. Interpreting facilities are available to cater for the multiple languages spoken including a Slovak Romani interpreter based at Lister house surgery five days a week. The practice also provides regular support to residents living in nine care homes. The level of deprivation within the practice population is above the national average with the practice rated in the second most deprived decile.

Lister House surgery is open between 7am and 7pm Monday to Friday. Oakwood medical centre is open from: 7am to 6.30pm on Monday and Friday; 8am to 6.30pm on Tuesday and Thursday and 7am to 12pm on Wednesday. The consulting times for clinicians varies but is usually from 7.20am or 8am to 6.30pm; with urgent appointments available from 8am to 12pm and 1pm 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 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 hold about the practice and asked other organisations to share what they knew. This included NHS England, Southern Derbyshire clinical commissioning group and Healthwatch. We carried out an announced visit on 13 October 2016. During our visits we:

- Observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- Reviewed 40 comment cards where patients shared their views and experiences of the service.
- Spoke with 25 patients who used the service and three members of the patient participation group.
- Spoke with a range of staff (GPs, the business practice manager, informatics manager, quality manager, assistant practice manager, reception and administration staff).
- We reviewed practice protocols and procedures and other supporting documentation including staff files and management records.

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

Detailed findings

- 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).

- Following our inspection, we also spoke with the health visitor and midwife, and obtained feedback from four care homes.

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, record and investigate significant events.

- Staff that we spoke with were aware of the significant event process and were able to describe their roles in incident reporting. Staff told us they would inform one of the managers of any incidents and complete a recording form available on the practice's computer system.
- Records reviewed showed 23 significant events had been recorded over the last 12 months. An analysis of each significant event was undertaken and the findings were discussed at regular staff meetings. Learning points were shared with the full practice team where appropriate. This included the management team disseminating a summary of significant events and agreed learning via a newsletter, notifications and emails to staff.
- We saw that policies and procedures were updated and staff received refresher training as part of learning when unintended errors or unplanned events had occurred.
- The practice team also undertook an annual review of significant events to consider any recurrent themes and to check that all follow-up actions had been completed and discussed with relevant staff. There were 25 significant events, five near misses and five positive events reviewed as part of the 2015/16 annual review.

Patient safety information including the Medicines and Healthcare Regulatory Agency (MHRA) alerts were received within the practice and one of the practice nurses took a lead role in disseminating the information to other clinical staff. We saw evidence of some alerts being acted upon by the nursing team and discussed at their regular meetings. Feedback from staff interviews did not assure us that an effective system was in place to ensure the practice acted on medicine safety alerts to keep patients safe.

However, following our inspection the practice provided documented evidence to show they had acted upon our initial findings by implementing a defined process to manage patient safety alerts. This included lead staff members being accountable for: maintaining a register of all incoming alerts, undertaking searches to identify

affected patients and reviewing their needs to ensure their safety. We were shown examples to demonstrate that some of the alerts had been responded to and the action plan in place to ensure this was continued post our inspection.

Overview of safety systems and processes

The practice had a lead and co-lead GPs for safeguarding children and vulnerable adults, and staff were aware of who this was. Most staff had received up to date training that was relevant to their role. GPs had been trained to child safeguarding level three. Training had been planned for the newly recruited staff and existing staff requiring refresher training.

A flagging system was in place for highlighting safeguarding concerns on patient records. For example, the practice had identified 45 children on child protection plans, 160 "children in need" and 27 children with "low level" safeguarding concerns. We received positive feedback from the midwife and health visitor in respect of the responsiveness of staff when safeguarding concerns were raised and regular communication that took place including the monthly safeguarding meetings.

Practice supplied information showed efforts were being made to improve the standards of the safeguarding registers (including coding of information) in liaison with the clinical commissioning group and health visiting teams. However, we found significant concerns in respect of record keeping, coding of patient records, information sharing and identification of vulnerable adults. For example:

- Comprehensive records and meeting minutes were not always maintained to evidence the identified safeguarding concerns for each patient and the agreed actions/measures to protect them. This did not ensure effective communication and access to up to date information by clinicians which would be important during consultations and decision making.
- Although improvement work was being undertaken to identify additional vulnerable adults, only 12 patients had been flagged on the system at the time of our inspection.

Due to the urgency of these concerns, we used our legal powers to request information and evidence to assure us that immediate actions were put in place to safeguard patients from abuse. Following our inspection, the practice provided evidence to demonstrate a series of actions had been initiated including a review of all safeguarding

Are services safe?

registers and procedures. Following our inspection, we received written evidence to confirm that safeguarding had been discussed at the practice away day held on 16 November 2016 and the tasks detailed in the action plan had been completed by 21 November 2016.

- The practice had a chaperone policy in place. Information was displayed within the practice advising patients they could request a chaperone, if required. Staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS) or had a risk assessment in place if a DBS check had not been completed.
- During our inspection we observed the practice to be visibly clean and tidy and this aligned with the views of patients. A practice nurse was the lead for infection prevention and control and they liaised with the local infection prevention teams to keep up to date with best practice. There were infection control protocols and policies in place and staff were provided with relevant training. This included use of ultra violet light training sets to demonstrate effective hand washing. Infection control audits were undertaken annually, the most recent being June 2016. We found action was taken or in progress of being completed to address identified improvements. Cleaning schedules were completed and regular monitoring arrangements were in place to ensure high standards were maintained.
- We saw evidence of clinical staff having received vaccinations to protect them against hepatitis B. Information relating to infection control and hand hygiene was displayed on the patient and staff noticeboards; and was also shared via the staff newsletter and nursing meetings to promote awareness.
- The arrangements for managing medicines and vaccinations in the practice mostly kept patients safe. Policies and procedures were in place to ensure the obtaining, prescribing, recording, handling, storing, security and disposal of medicines was implemented in line with best practice guidance. Blank prescriptions were securely stored and there were systems in place to monitor their use.
- The practice had strengthened its processes for reviewing high risk medicines and recalling patients for blood monitoring and medicine reviews prior to our inspection. The practice carried out medicine audits

with the support of the local clinical commissioning group pharmacy teams to ensure prescribing was in line with best practice guidelines for safe prescribing. The provider employed a practice pharmacist and this increased the capacity to review patients' medicines and deal with prescription queries which freed up GP time.

- Five of the practice nurses were qualified independent prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the GP partners for this extended role. Patient group directions were in place to allow nurses to administer medicines in line with legislation, and there was a system for the production of patient specific directions to enable health care assistants to administer specific medicines when needed.
- We reviewed five personnel files and found most of the appropriate recruitment checks had been undertaken prior to employment. This included proof of identification, employment history, qualifications, registration with the appropriate professional body (nursing and midwifery council and general medical council) and the appropriate DBS checks.

Monitoring risks to patients

Most risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. A review of the health and safety policy and procedures had been undertaken in June 2016.
- The practice had fire procedures in place including an up to date fire risk assessment. Most staff had completed their fire safety training and other staff had their training already planned. Designated staff members had also received fire marshal or fire officer training. Fire alarm tests were undertaken weekly and the most recent fire evacuation drill had been completed in May 2016 (Lister house surgery) and July 2016 (Oakwood medical centre).
- Electrical and fire equipment had been checked to ensure they were safe to use and working properly. For example, portable appliance testing had been completed in April 2016 and clinical equipment had been calibrated in March 2016 at both surgeries.

Are services safe?

- The practice had a variety of other risk assessments in place to monitor the safety of staff and the premises. For example, risk assessments related to the work environment, control of substances hazardous to health and legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings. Records reviewed showed appropriate action was taken to address any identified risks to ensure these were mitigated.

Arrangements were in place to plan and monitor the number and skill mix of staff needed to meet patients' needs.

- The practice had undertaken an analysis of patients' needs and the demand for services to inform the staffing levels. The needs analysis and planned service developments had in part, informed a recent recruitment drive that had resulted in increased staffing levels (both clinical and non-clinical staff). Most staff worked at both Lister house surgery and Oakwood medical centre. Non-clinical staff we spoke to told us they were sufficiently staffed on most occasions and routinely covered for each other during periods of absence, annual leave or sickness. A rota system for all the different staffing groups was in place to monitor and ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

- The practice had adequate 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.
- Most staff had completed their basic life support and anaphylaxis training. Plans were in place for recently recruited staff or those on leave to complete their refresher 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. This included the National Institute for Health and Care Excellence (NICE) best practice guidelines and local prescribing guidelines.

- Systems were in place to ensure all clinical staff had easy access to current guidelines. For example, any new or revised guidance and updates were discussed at regular clinical meetings and were stored electronically on the staff intranet.
- We observed the practice's weekly GP operations meeting which included discussions on best practice guidelines, significant events, the needs of patients and clinical governance for example. The meeting promoted engagement within the practice by including all GPs, advanced nurse practitioners, clinical and non-clinical leads.
- 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 2015/16 published results showed that the practice had achieved 96.4% of the total number of points available compared to the clinical commissioning group (CCG) average of 97.2% and the national average of 95.3%.

The practice had an overall exception reporting rate within QOF of 14.4% which was 2.7% above the CCG average and 4.6% above the national average. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. The practice was of the view that the high exception reporting was a reflection of some groups of patients not engaging fully with their healthcare.

- Performance for diabetes related indicators was 97% which was above the CCG average of 93% and the national average of 90%. The exception reporting rate for all 10 diabetes related indicators was above the local and national averages.

The decision to exception report by practice staff was based on the following reasons: patients who had given informed dissent by not attending their health reviews in spite of being invited on three occasions and patients for whom prescribing a specific medicine or treatment was not clinically appropriate. The practice was of the view that the high exception reporting was a reflection of some groups of patients not engaging fully with their healthcare.

The practice had improved the process for reviewing patients diagnosed with diabetes within the last year. Patients were first invited for an appointment with a health care assistant to obtain blood samples and check their blood pressure for example; and test results were sent to them prior to a follow up appointment with a practice nurse of their choice. The impact of this was that patients were kept informed of their condition and the time spent with a practice nurse was reduced from 30 minutes to 20 minutes. This enabled the practice to offer more appointments.

- Performance for hypertension related indicators was 85.2% which was 13.5% below the CCG average and 12.1% below the national average. Approximately 73% of patients with hypertension had their last blood pressure reading measured in the preceding 12 months compared to the CCG average of 84% and the national average of 83%. The exception reporting rate for this indicator was about 4% which was in line with the CCG and national averages.
- Performance for mental health related indicators was 99.96% which was 3.4% above the CCG average and 7.1% above the national average. The exception reporting rate was below the local and national averages for five out of six mental health related indicators.
- Performance for dementia related indicators was 100% which was 0.4% above the CCG average and 3.4% above the national average. All patients (100%) diagnosed with dementia had their care reviewed in a face to face meeting in the preceding 12 months compared to the CCG average of 85% and the national average of 84%.

Are services effective?

(for example, treatment is effective)

The exception reporting rate for this indicator was 6.6% which was below the CCG average of 7.9% and the national average of 6.8%. The practice had engaged in the dementia screening pilot in collaboration with specialist nurses and the dementia diagnosis rate was 70% compared to a local average of 59%.

There was evidence of quality improvement including clinical audit.

- There had been a number of clinical audits completed in the last two years, including completed audits where the improvements made were implemented and monitored.
- We reviewed three audits in detail. For example, the practice undertook annual audits relating to minor surgery to consider compliance to one of four key areas (wound infection) recommended by the royal college of GPs and department of health. The initial audit completed in 2013 showed one of 41 patients (2.4%) had a post-surgical procedure infection necessitating antibiotics. Recommendations were made and re-audits were undertaken. The second re-audit demonstrated a 0% rate of post-surgical infections for 123 procedures carried out between April 2015 and March 2016. The audit also considered other areas such as consent.
- The GPs, advanced nurse practitioners and practice employed pharmacist, worked with the CCG pharmacist to undertake prescribing audits to ensure that changes to prescriptions or dosages had been implemented.
- The practice participated in local audits, benchmarking and peer review with other local practices in Derby city. The CCG weighted benchmarking data for the period September 2015 to 31 August 2016 showed hospital emergency admissions were marginally below the CCG and national averages; whilst the accident and emergency attendances were above the local and national averages.

Effective staffing

Staff had a range of experience, skills and knowledge which enabled them to deliver effective care and treatment.

- The practice had a comprehensive and role specific induction programme for newly appointed clinical and non-clinical staff. This covered areas such health and

safety, information governance and confidentiality. Records reviewed showed topics were signed off once completed and staff had an option to complete a feedback form to improve the induction process.

- Staff told us they were supported during their induction and probation periods with shadowing opportunities and had regular reviews with their line manager.
- Daily mentor and debrief sessions were in place to support GP registrars in their roles.
- Apprenticeships were offered for non-clinical roles (reception and administration) resulting in some staff being recruited as employees at the end of their apprenticeship.
- Staff had access to training to meet their learning needs and to cover the scope of their work. This included e-learning training modules, in-house training, clinical supervision and support for GP and nurse revalidation.
- The practice held monthly educational forums to which external speakers were invited. Recent topics covered included care and treatment of glaucoma, osteoporosis and dementia.
- The practice also held a fortnightly team meeting (referred to as “young doctors group”) which served as an educational forum and supportive mechanism for discussing the clinical care of specific patients.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which included an assessment of competence. Staff who administered vaccines stayed up to date with changes to the immunisation programmes by accessing on line resources and discussion at practice nurse meetings.
- The practice provided protected learning time to support monthly nurse team meetings.
- Staff employed for over a year received an annual appraisal and we saw documentation that evidenced this. The appraisal included a review of the staff member’s performance in the preceding year and the identification of learning needs and objectives for the forthcoming year.

Are services effective?

(for example, treatment is effective)

- The clinical team had areas of specialties allowing the most appropriate clinician to care for patients. This included employing a pharmacist, community mental health nurse, a community support worker and a care home specialist nurse.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice audited its referrals to drive improvements in the timeliness and quality of information recorded and shared with other agencies. This included reviews of "two week wait" referrals.

The practice team worked collaboratively with other health and social care professionals to: assess the range and complexity of patients' needs; and plan on-going care and treatment. Weekly multi-disciplinary meetings were held between practice clinicians and representatives from social services and Derbyshire community health services. For example, the community matron, district nurses, a care coordinator and the Macmillan nurse. The meetings focused upon: patients at high risk of hospital admission with the purpose of expediting the discharge of patients with complex long term conditions or frail elderly by providing care closer to or at home. Care plans were routinely reviewed by relevant staff leads and updated.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- Consent obtained was recorded in the patient records and we saw evidence of this.

- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients at risk of developing a long-term condition, patients with a learning disability and / or experiencing poor mental health. Patients were then given advice and / or signposted to the relevant service and this included Livewell. Livewell is a healthy lifestyle service for patients registered with a doctor in Derby. It offers free 12-month programmes to help adults and children improve their health and wellbeing. For example, weight management, healthy pregnancy, stop smoking, child weight management and men's health.

- There were 172 patients identified as having learning disability in 2016/17. A total of 68 patients (about 40%) had received a review and a further 21 (12%) patients had appointments planned.

The practice provided new patient health checks and NHS health checks for patients aged 40 to 74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. For example, an audit completed in October 2016 by the lead nurse showed:

- 1 313 patients were invited for NHS health checks and 546 patients (42%) had received screening in 2015/16. Records reviewed showed this was the highest uptake rate of NHS health checks in Derby City.
- 57 out of 546 patients (10%) had raised blood sugars putting them at risk of diabetes and four of these patients were diagnosed with Type 2 diabetes.
- Five patients were diagnosed with hypertension and required medicines to control blood pressure and 41 patients were found to have high cholesterol levels requiring clinical input, lifestyle and dietary advice.

The practice's uptake for the cervical screening programme was 83.5% which was the same as the CCG average and above the national average of 82%. Systems were in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Are services effective?

(for example, treatment is effective)

Patients were encouraged to attend national screening programmes for bowel and breast cancer screening. The published cancer data for 2014/15 showed the practice's uptake rate for:

- Breast cancer screening in the preceding three years was 71% compared to the CCG average of 76% and the national average of 72%.
- Bowel cancer screening was 51% which was below the CCG average of 60% and the national average of 58%. The practice had identified a training awareness programme with NHS England and planned to train a nurse champion in this area to increase uptake.

Immunisation rates for the vaccinations given to children were mostly in line with CCG and national averages as at March 2016. For example:

- Childhood immunisation rates for the vaccinations given to under two year olds ranged from 65% to 96% compared to the CCG range of 67% to 97% and the national range of 73% to 95%.
- Childhood immunisation rates for the vaccinations given to five year olds ranged from 74% to 100% compared to the CCG range of 72% to 98% and the national range of 81% to 95%.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed patients being treated with dignity and respect by staff, both on the telephone and in person. Staff greeted patients politely as they presented at reception and their individual needs were accommodated. This included access to an onsite interpreter for patients whose first language was Slovak Romani or Slovak Romanian.

We found suitable arrangements were in place to ensure the privacy and dignity of patients was maintained. For example:

- Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.
- Curtains were used around the bed during examinations, investigations and treatments to provide additional privacy and dignity.
- Patients were offered a private room if they wanted to discuss sensitive issues in confidence or appeared distressed.
- A privacy notice was also displayed in the reception area to encourage patients to respect each other's privacy when discussing their health needs with the reception staff.

We spoke with 25 patients including patients whose first language was Slovak Romani or Slovak Romanian via our interpreter. Most patients said they were satisfied with the care provided by the practice and were treated with compassion and respect by staff. We also spoke with three members of the patient participation group (PPG) who praised the staff highly and gave examples to demonstrate how staff had responded compassionately when they needed help and support provided.

All of the 40 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said the practice offered a very good service and staff were courteous, understanding and caring. Some patients also gave specific names of GPs and nurses whom they felt had been very supportive and reassuring in the treatment and care they had received. Seven out of 10 comments received from Healthwatch were also positive about the care received.

The results from the national GP patient survey, published in July 2016, showed most patients felt they were treated with compassion, dignity and respect. The practice was in line with or marginally below the local and national averages for satisfaction scores on consultations with GPs. For example:

- 97% of patients said they had confidence and trust in the last GP they saw compared to the clinical commissioning group (CCG) average of 96% and the national average of 95%.
- 81% 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%.

Satisfaction scores for interactions with reception staff and nurses were above or in line with the CCG and national averages. For example:

- 95% of patients found the receptionists helpful compared to the CCG average of 88% and the national average of 87%.
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern, compared to the CCG average of 94% and the national average of 91%.

Care planning and involvement in decisions about care and treatment

Most patients told us they felt involved in decision making about the care and treatment they received. This included being listened to by staff and having 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 mostly positive and aligned with these views.

The national GP patient survey results showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 89% of patients said the GP was good at listening to them compared to the CCG average of 90% and the national average of 89%.
- 83% of patients said the last GP they saw was good at explaining tests and treatments, compared to the CCG and national averages of 86%.

Are services caring?

- 83% of patients said the GP gave them enough time compared to the CCG and national averages of 87%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national averages of 82%.

Higher satisfaction scores were achieved for nurses. For example:

- 94% of patients said the nurse was good at listening to them compared to the CCG average of 93% and national average of 91%.
- 92% of patients said the last nurse they saw was good at explaining tests and treatments, compared to the CCG average of 91% and national average of 90%.
- 93% of patients said the nurse gave them enough time compared to the CCG average of 93% and national average of 92%.
- 89% 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%.

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

- Information for patients was available in a range of languages and format, including other languages, easy read and use of pictures for people with a learning disability.
- Patients were encouraged to contribute to their care plans and we saw examples of completed “do not resuscitate” forms and personalised care plans for patients on the palliative care register. Information was also shared with the out of hours service including the patient’s preferred place of death and prescribed anticipatory medicines.

Patient and carer support to cope emotionally with care and treatment

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

organisations. This included information related to carers, specific long term conditions, psychological therapies, dementia and mental health. The practice employed community support worker and attached care coordinator also signposted carers to sources of help and advice if needed.

The emotional and social needs of patients and carers were seen as important as their physical needs. For example:

- The practice had hosted its first dementia café event in May 2016 in partnership with the PPG and representatives from Making Space and Derbyshire city dementia services. Dementia cafés give both carers and people with dementia a chance to get information, advice and to talk to others with similar problems. The practice told us between 15 to 20 people had attended and we received positive feedback about the event from the PPG members we spoke to.
- The practice’s computer system alerted GPs if a patient was a carer and a designated member of staff was the carer’s champion. The practice had identified 189 carers and this equated to 0.8% of the patient list. Efforts were being made to increase the number of identified carers. For example, regular carer events/cafes were hosted in the practice and this included representatives from Derbyshire carers association. A carers register was used to support these patients including inviting them for health checks. Longer appointments were offered if appropriate, as well as home visits to fit around the often busy lifestyle of a carer.

An invitation was 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 if families experienced bereavement their usual GP or the practice employed mental health nurse contacted them if this was considered appropriate. This call was either followed by a patient consultation at a flexible time and location to meet the family’s needs, giving them advice on how to find a support service.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England area team and clinical commissioning group (CCG) to secure improvements to services where these were identified. This included providing integrated and person-centred pathways of care for people with multiple and complex needs. For example:

- As part of a community project, the practice engaged with two local practices and Derbyshire community health services to “identify the support needs and improve the management of patients who frequently accessed health and social care services with a view to reducing admissions”. The practices received funding to support a dedicated GP resource to lead the weekly collaborative meetings with the community team where complex cases were discussed and plans agreed. The practice had evaluated the benefits of this project for the period November 2015 to July 2016 and quantitative data showed positive outcomes were achieved for patients and the practice. The findings showed: a reduction of acute GP visits by 38%; a reduction of GP appointments by 29%; a reduction of nurse appointments by 34% and an overall reduction in accident and emergency admissions with significant cost savings for the CCG.
- In addition, records reviewed showed a residential care home was requesting 13 to 16 GP visits each month for 10 residents registered with the practice. Initially, joint visits were undertaken by the GP lead and attached community matron to ensure patients received a comprehensive and holistic review of their care needs in their home. As a result of this intervention, the number of visit requests dropped to zero a month (although one was requested when the community matron was on annual leave). The community matron now visits the care home on a weekly basis to review the patients' health needs reducing the number of home visits made by GPs.
- The GPs provided regular “ward rounds” to nine 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. In response to this, a care home specialist nurse was

employed to coordinate the care of residents living in care homes with support from the GPs. Within a six week period, the nurse had completed the following interventions: 62 medication reviews; 40 dementia annual reviews, 19 diabetes reviews and 59 new care plans had been put in place for example. The visits undertaken by the nurse meant 67 face to face GP visits were not required. Records reviewed (patient satisfaction questionnaires) showed patients were positive about the service received. They felt their health and care needs were fully met and excellent care was provided.

- The practice employed an independent prescribing pharmacist as part of a NHS England pilot scheme. Records reviewed showed the pharmacist had made contact with 296 patients from June to September 2016. Their input had resulted in increased clinical capacity to review patients' medicines including people with long term conditions such as rheumatoid arthritis and patients presenting with minor illnesses. This also freed up GP time to provide care for patients with more complex needs. The pharmacist also provided advice to staff on medicines information and supported the nurses during their clinics thereby sharing their expertise.

The practice hosted and facilitated community based services which enabled care to be provided closer to home for patients.

- Since 2010, the practice had hosted a GP led community musculoskeletal assessment and treatment service which 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 practice also hosted an onsite physiotherapy service.
- The practice hosted consultant led ‘first outpatient spinal clinics’ operated by Royal Derby Hospital. This allowed a closer working relationship between the GPs and consultants.
- Patients with diabetes could have their insulin treatment initiated at the practice and where appropriate were referred for a six week educational



Are services responsive to people's needs?

(for example, to feedback?)

programme to equip patients with the skills to better manage their diabetes. One of the advanced nurse practitioners was part of the CCG task force involved in re-designing a community based diabetes service.

Services were tailored to meet the needs of people experiencing poor mental health and those living in vulnerable circumstances to ensure flexibility, choice and continuity of care. For example:

- The practice employed its own mental health nurse (19 hours a week) and a full-time community support worker to provide care for patients who needed support with mental health including counselling and signposting to support groups or other agencies. 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.
 - Feedback from a mental health recovery worker at Rethink Derby Steps showed patients were referred in a timely manner 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.
 - Patients described as sleeping rough in Derby city could access services at this practice and were signposted to other agencies for support.
 - The patient participation group (PPG) and practice had hosted an alcohol and drug awareness drop in session in August 2016, in collaboration with a local drug and alcohol support service. Patients had access to information, advice and an assessment in respect of alcohol misuse. A total of 34 questionnaires were completed including two referrals.
 - The practice hosted annual visits for up to 60 children from the local primary school at the practice. The purpose of the visits included health education in a "fun and welcoming environment". Information shared related to the role of the body organs, exercise, healthy eating and demonstration of effective handwashing for example.
- The individual needs and preferences of patients were central to the planning and delivery of tailored services. The services offered were flexible, provided choice and promoted equality.
- The reception team operated a 'special patient list' which included a list of patients that had been identified as having particular challenges accessing services. This included people with hearing impairments or from the deaf community, those experiencing poor mental health or at risk of isolation. At the time of inspection about 50 patients had been identified and arrangements were in place to assist them access services when needed.
 - The Citizens Advice Bureau offered on-site appointments for patients at the practice.
 - Translation services were available for patients who did not have English as a first language. For example, the practice employed a Slovak Romani interpreter five days a week to ensure the communication needs of about 4000 patients from the Romani Slovak community were met. This service was highly appreciated by patients we spoke to. However, two comments received from Healthwatch highlighted these patients had not been supported with an interpreter when needed.
 - 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, as well as their preferred contact method and other support needed.
 - Nurse led minor illness clinics were available to patients and a range of treatment room services were provided including phlebotomy.
 - Sexual health and contraceptive services were provided including the fitting of implants and coils. A total of 28 patients had completed a satisfaction survey relating to intra uterine contraception devices and all of them stated they were involved in decisions about their care and received relevant information about the procedure and aftercare.
 - The practice provided a comprehensive travel vaccination service and was a designated yellow fever vaccination centre.
 - Ante-natal appointments were available with community midwives and post-natal checks were provided within the practice by the nurse and GP.

Access to the service

- Lister House surgery was open between 7am and 7pm Monday to Friday.



Are services responsive to people's needs?

(for example, to feedback?)

- Oakwood medical centre was open from: 7am to 6.30pm on Monday and Friday; 8am to 6.30pm on Tuesday and Thursday and 7am to 12pm on Wednesday.

The consulting times for clinicians varied but were usually from 7.20am or 8am to 6.30pm; with the nurse triage system operating from 8am to 10.30am and 2pm to 4.30pm and the GP triage operating from 8am to 12pm and 1pm to 6.30pm daily. Routine appointments could be pre-booked up to two weeks in advance

When patients called for an appointment, the call was directed to non-clinical staff working in the practice call centre between 8am and 6.30pm. The provider had developed and implemented a “medical assessment triage protocol” based on clinical algorithms for use by non-clinical staff (reception team). A clinical algorithm consists of a step-by-step protocol for managing a specific health need, each step depending on the outcome of the previous one. The protocol enabled the reception team to direct patients to the most appropriate clinician in a timely manner without them making a clinical decision. Symptoms were prioritised according to the clinical algorithm and patients were given an urgent appointment according to their clinical need. Same day appointments were available for children and given a high priority in the triage protocol. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. We received positive feedback from both staff and patients regarding the triage system. The practice told us the triage system was aimed to enable them to make telephone contact or see all patients on the day they called. The protocol had been commended by the CCG who were liaising with the provider to see whether it could be shared more widely.

Seven comment cards contained less positive feedback relating to telephone access, availability of appointments, not always being seen by their preferred doctor and continuity of care not being maintained. However, most of the patient feedback we received highlighted that people were able to get appointments when they needed them. This was aligned with the practice's 2016 patient survey results.

The national GP patient survey results which showed that patient's satisfaction with how they could access care and treatment was mostly above local and national averages.

- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 76%.
- 85% of patients said they could get through easily to the surgery by phone compared to the CCG average of 72% and the national average of 73%.
- 73% of patients described their experience of making an appointment as good compared to the CCG average of 72% and the national average of 73%.
- 72% patients felt they don't normally have to wait too long to be seen compared to the CCG average of 62% and national average of 58%
- 66% usually get to see or speak to their preferred GP compared to the CCG average of 55% and national average of 59%.

Listening and learning from concerns and complaints

The practice had effective systems in place to handle concerns and complaints.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The business practice manager was the designated responsible person who handled all complaints in the practice. They were supported in their role by a GP lead for complaints handling and a complaints administrator.
- Information was available in the waiting area and practice website to help patients understand the complaints system. This included posters and the practice leaflets.

The practice had logged 48 complaints in the last 12 months. We reviewed six complaints in detail and found these were dealt with promptly and sensitively. The practice provided people with explanations and apologies where appropriate. Complaints were discussed at practice meetings and where appropriate reviewed as significant events. Lessons learned from complaints and trend analysis were used to improve the quality of care and staff were informed of outcomes. Learning was shared with staff, the patient participation group and other stakeholders were appropriate.

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 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 to knew and understood the practice values and there was a high degree of ownership of the vision.
- The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable. For example, Dr Moss and Partners (the provider) had been managing two practices (Lister house at Chellaston and Lister house at Coleman) on a “caretaker” basis since January 2016. Our inspection of Lister house at Chellaston on 18 November 2016 showed significant improvements had been made to patient care and staff welfare as a result of their input. This included improved telephone systems and a clinical support structure was implemented.
- The practice business plan included objectives relating to re-structuring of staff roles across the four surgeries, collaborative working and a commitment to developing patient services.

Governance arrangements

The overarching governance framework required strengthening to ensure robust systems and processes were in place for identifying, recording and managing risks to patients.

- Specifically, we found that systems and processes in place to respond to safety alerts and safeguard patients from abuse were not always operating effectively. For example, most of the records we reviewed (including safeguarding meeting minutes) were not complete and contemporaneous. We were concerned this did not ensure all clinicians had access to detailed safeguarding

information when delivering care and treatment and this could impact on information not being shared immediately to protect those who were vulnerable to abuse.

- The provider’s immediate response to implementing mitigating action to address the areas of concern demonstrated responsiveness and a commitment to ensuring the safety of patients.
- Following our inspection, the provider submitted additional evidence to demonstrate improvements had been made, however this required embedding to ensure changes were sustained.

We found most of the arrangements for governance and performance management were regularly monitored, improved and adjusted to accommodate the growth of the practice and to improve patient care. The governance arrangements included the following:

- There was a clear staffing structure and staff we spoke to were aware of their delegated roles and responsibilities.
- Practice specific policies were implemented and 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 had a structured business approach to the management of the service.

Leadership and culture

The GP partners and management team demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Some of the GPs and management staff had lead roles within the practice and were involved in external engagement within the locality, the local medical committee and the clinical commissioning group (CCG). The strategic roles of staff enabled them to share best practice with the wider team and improve the quality of care for patients. For example, one of the GPs was the locality lead and planned care lead for Derby commissioning Network Locality (DCN). Another GP was part of the CCG clinical improvement group.

Are services well-led?

Good 

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

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

- Staff described the leadership team as being visible in the practice, approachable and took the time to listen to them.
- There was a rolling programme of regular meetings held within the practice which facilitated communication and improvement across all staffing groups. This included meetings for GP partners, the management team and clinical staff. Periodic meetings were held for reception staff with regular updates communicated via notifications, emails and / or a staff bulletin.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- The GP partners and management team encouraged staff to identify opportunities to improve the service delivered by the practice. Staff told us they would not hesitate to share their ideas for improvement and were proud of the services the practice offered.

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

The practice proactively engaged patients in the delivery of the service and valued their feedback.

- The practice gathered feedback from patients through the patient participation group (PPG), practice and friends and family test surveys. The PPG meetings were held every six weeks and regular members were visible within the practice with a designated space and information board. They were proactive in promoting patient education; fundraising activities and ensuring proposals for improvements were acted upon. The three PPG members we spoke to felt well supported and listened to by the leadership team.
- The GP partners and practice management team encouraged staff engagement and promoted an ethos of team working within the practice. For example, staff took part in social activities outside of work and an away day had been planned for November 2016.
- The practice proactively gathered feedback from staff through surveys, feedback forms, staff meetings,

appraisals and discussions. Staff told us they felt involved and engaged to improve how the practice was run. Changes made as a result of staff feedback included recruitment of additional staff.

Continuous improvement

There was a strong focus on continuous learning, improvement and education 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. This included employing an independent prescribing pharmacist for three days each week to deal with medicine related and participating in a locally commissioned service framework project on psychosis.

The practice was engaged in new models of working including place based working. For example, the practice was a founding member of Alexin Healthcare, a federation of 91 GP practices based in in Southern Derbyshire and South east Staffordshire. The federation aimed to develop frameworks and relationships that took advantage of economies of scale and improved ways of working. The practice had helped set up projects relating to health checks, GPs working in accident and emergency, geriatric wards and developing a referrals triage system.

The practice had a strong focus on education and the professional development of staff was recognised as integral to ensuring high-quality care. For example:

- The practice was GP training practice with three trainers. The practice partnered with a local practice and Alexin Healthcare in providing a training hub for medical students nurses and sixth form students. Training Hubs are part of a Health Education East Midlands (HEEM) project to improve recruitment and retention of GPs and the wider general practice team. The hub is currently engaging with at least 20 practices.
- One of the advance nurse practitioners (ANP) was engaged in a project with HEEM to determine and provide a consistent level of training and qualification for ANPs. The same ANP was also an accredited GP trainer and assisting with a project to formalise training for advanced care practitioners in Southern Derbyshire.
- Staff attended locality meetings, practice managers' and nurse forums as part of collaborative working and sharing of best practice.

Are services well-led?

Good 

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

The practice engaged in 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.
- Implementation of an interactive messaging system (MJOG) which is a two way patient communication
- Trialling the new Southern Derbyshire CCG infection prevention and control audit gold standard.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>How the regulation was not being met:</p> <p>The systems and processes in place were not established and always operating effectively to safeguard children and vulnerable adults. We found safeguarding did not have the right level of scrutiny and oversight to ensure that people were protected from abuse and improper treatment. For example, high numbers of patients were recorded on the child safeguarding registers with limited oversight of the safety or protection plans in place to safeguard some of the patients.</p> <p>The systems in place for identifying vulnerable adults at risk of abuse were not robust and indicated underreporting. For example, only 12 patients had been flagged on the system at the time of our inspection and our review of patient records showed additional vulnerable adults that required flagging and monitoring.</p> <p>This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>