Ashgate Medical Practice

Quality Report

Ashgate Manor
Ashgate Road
Chesterfield
Derbyshire
S40 4AA
Tel: (01246) 232946
Website: www.chesterfieldmedicalpartnership.co.uk

Date of inspection visit: 31 August 2016
Date of publication: 21/11/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ashgate Medical Practice on 31 August 2016. Overall the practice is rated as good.

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

- There was an effective system in place for the reporting and recording of significant events. The practice had adapted a system from a neighbouring practice termed learning opportunities to share (LOTS) to encourage incident reporting at all levels within the practice. This encouraged staff to raise events, however minor or significant, with the resulting impact of issues increasingly being reported. Learning was applied from all events to enhance the delivery of safe care to patients.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- A regular programme of clinical audit and research reviewed patient care and ensured actions were implemented to improve services as a result.
- The practice planned and co-ordinated patient care with the wider multi-disciplinary team to deliver effective and responsive care to keep vulnerable patients safe.
- The practice had an effective appraisal system in place, and was committed to staff training and development. The practice team had the skills, knowledge and experience to deliver high quality care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice analysed and acted on the patient and staff feedback they received, and worked with a proactive Patient Participation Group (PPG) to enhance patient experience.
- Information about how to complain was readily available to patients. Improvements were made to the quality of care as a result of any complaints received.
- Results from the national GP survey and feedback from patients we spoke with during the inspection demonstrated some dissatisfaction with the

Summary of findings

appointment system. The practice was aware that access was problematic and had taken action to address this. This matter remained under review by the practice as they strove to improve access.
- Longer appointments were available for those patients with more complex needs. A GP triaged calls and ensured that any patient requiring an urgent appointment was seen on the same day.
- There were elements of the practice's quality monitoring arrangements, and the actions taken to reduce risks, that required strengthening. For example, the practice had not arranged for Disclosure and Barring Service (DBS) checks on two staff who had been trained to act as chaperones. In addition, some medicines management issues such as the checking of medicine expiry dates lacked sufficient oversight and required more robust management. However, the practice took immediate action to rectify these issues.
- The practice had modern purpose-built facilities that were well-equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and the practice had a governance framework which supported the delivery of good quality care. Regular practice meetings occurred, and staff said that the GPs and managers were approachable and always had time to talk with them.
- The practice had a clear vision for the future and the aspirations of the partners were in line with the CCG strategy of delivering high quality care closer to the patient's home.

We saw the following area of outstanding practice:

- The practice had commenced an in-house pharmacy pilot project from September 2015. This placed a prescribing community pharmacist within the practice for four days each week. The pharmacist had made 2,173 patient contacts between September 2015 and April 2016, approximately 75% of which were face to face consultations. This had a significant impact in releasing additional GP consultation capacity, and providing expert advice and support to patients and the practice team with regards to medicines related issues.

The areas where the provider should make improvement are:

- Consider the frequency and oversight of regular reviews for emergency medicines so that they are available when needed.
- Review procedures to monitor prescriptions, including the destruction of prescriptions assigned to a named GP after leaving the practice.
- Ensure the practice cold chain policy is implemented, supported by staff training, and with regular monitoring arrangements to provide assurance that it is being followed.
- Review procedures to ensure all staff who act as a chaperone receive appropriate DBS clearance.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Staff reported significant events, and learning was applied from incidents to improve safety in the practice. A team approach had been adopted to create an open and transparent environment for staff to raise significant events, supported by a simplified process for lower-level reporting called “learning opportunities to share” (LOTS). This resulted in an increase in reporting which was inclusive of the whole practice team.
- The practice had a designated infection control lead who undertook regular audits. Action was taken in response to any areas identified as requiring improvement.
- The practice adhered to written recruitment procedures to ensure staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- The practice mostly had systems and processes in place to keep people safe and safeguarded from abuse. However, not all non-clinical staff who acted as chaperones had received an appropriate disclosure and barring service (DBS) check.
- Some procedures to oversee the management of medicines and prescriptions within the practice required strengthening. This included the monitoring of expired medicines and the control of prescriptions within the practice.
- Patients on high risk medicines were monitored on a regular basis, and uncollected prescriptions were monitored by practice staff. Actions were taken to review any medicines alerts received by the practice, to ensure patients were kept safe.
- The practice ensured staffing levels were sufficient at all times to effectively meet their patients’ needs.
- The practice had robust business contingency arrangements, supported by a comprehensive and up to date written plan.

Are services effective?

Good

- The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Data showed patient outcomes were mainly in line with average for the locality. The practice had achieved an overall figure of 92.8% for the Quality and Outcomes Framework

Summary of findings

2014-15. This was 5.3% below the CCG average and 1.9% below the national average. The practice was able to provide data (which remained subject to external verification) for 2015-16 demonstrating an increase to 96.5% achievement.

- A regular programme of clinical audit demonstrated quality improvement, and we saw examples of full cycle audits that had led to improvements in patient care and treatment.
- A GP partner undertook regular research work which had received national recognition.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- New employees received inductions, and all members of the practice team had received an appraisal in the last 12 months including a review of their training needs.
- The practice was committed to staff development at all levels and encouraged opportunities for individuals to enhance their skills within a supportive environment.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs, in order to deliver care effectively. This was supported by fortnightly meetings attended by a range of health and care professional staff.

Are services caring?

Good

- We observed staff treating patients with kindness and respect, and staff maintained patient confidentiality throughout our inspection.
- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated they were treated with compassion, dignity and respect and felt involved in decisions about their care and treatment.
- Data from the latest GP survey showed that patients generally rated the practice in line with local and national averages in respect of care.
- Feedback from community based health care staff and care home staff was consistently positive with regards to the care provided by the practice team.
- The practice had identified 1.3% of their patient list as being carers. Information was available on the various types of support available to carers. Two members of the practice team were nominated as carers' champions.

Summary of findings

Are services responsive to people's needs?

Good

- Results from the national GP patient survey, comment cards and patients we spoke with during the inspection provided mixed views about their experience in obtaining a routine appointment. The practice was aware of this and was proactively taking action to improve this – for example, offering a range of appointments to see the nurse practitioners or community pharmacist as an alternative to a GP consultation.
- Urgent appointments were available on the day further to GP triage.
- The practice hosted a range of services on site which made it easier for their patients to access locally. This included a Citizens Advice Bureau session to assist patients with benefits advice; the abdominal aortic aneurysm screening programme; and a local service aimed at promoting healthier lifestyles.
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The premises provided modern and clean facilities and was equipped to treat patients and meet their needs. The practice accommodated the needs of patients with disabilities, including access to the building through automatic doors.
- The practice provided care for people living at two local care homes. We spoke with representatives from each home who informed us that the practice was responsive to their patients' needs. Fortnightly visits by a named clinician ensured patients were reviewed regularly.
- Information about how to complain was available in the waiting area. Learning from complaints was shared with staff to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they were offered a private room to ensure their privacy.

Are services well-led?

Good

- The partners had a strong commitment to delivering high quality care and promoting good outcomes for patients. There was a focus on future service delivery and the practice had started to create a five year forward plan.
- There was a clear leadership structure and staff told us that they felt supported and valued by the partners and practice management. The practice had an 'Above and Beyond' scheme to acknowledge staff who had provided exceptional work.

Summary of findings

- The partners worked collaboratively with the CCG and with other GP practices in their locality.
- The partners reviewed comparative data provided by their CCG and ensured actions were implemented to address any areas of outlying performance.
- The practice held regular staff meetings, and members of the practice team informed us that communication was effective and they felt involved in how the practice was run.
- The practice had developed a range of policies and procedures to govern activity.
- The practice had an active Patient Participation Group (PPG). This group proactively engaged with the practice, and made suggestions to improve services for patients.
- The practice used innovation measures to shape service delivery. For example, the practice had been selected as a pilot site to provide access to a community pharmacist within the practice.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

- The practice had slightly higher numbers of older people registered with them compared to the national average (for example, 20.6% of patients were over 65, compared against a national average of 17.1%). The practice ensured that their services were tailored to meet the needs of their older patients.
- The practice employed a full-time community matron to focus upon the needs of older patients to avoid hospital admissions and to facilitate discharges from secondary care.
- The practice provided a number of in-house services to prevent older patients from travelling to a hospital or other locations to access them. This included wound care, ECGs, phlebotomy, and 24 hours blood pressure monitoring.
- The practice had an integrated approach in working with other professionals to plan and deliver care, and held fortnightly multi-disciplinary meetings to review their most vulnerable patients.
- Longer appointment times were available and home visits were available for those unable to attend the surgery. Nurse practitioners undertook home visits for some acute health care needs with appropriate support and advice being provided by GPs.
- Fortnightly visits were provided by a named GP or a nurse practitioner to a local care home aligned to the practice. The practice responded to any urgent patient needs on the same day. The practice provided data to demonstrate a reduction in hospital admissions from the home from 35 in 2013-14, to 14 in 2015-16. Accident and Emergency (A&E) attendances had reduced by 50% within this timescale. This indicated that the input the practice team provided to the care home had impacted positively upon secondary care admission rates.
- Uptake of the flu vaccination for patients aged over 65 was 75.8% which was in line with local (73.9%) and national (70.5%) averages.

People with long term conditions

Good

- The practice generally had a higher prevalence of most long-term conditions and designed service delivery around the needs of their patients.

Summary of findings

- The practice achieved 78.1% for diabetes related indicators during 2014-15, which was below the local average of 96.7% and below the national average of 89.2%. However the rates of exception reporting were generally lower.
- Patients received an annual review of their conditions including their prescribed medicines. This review was done within the patient's home if they had difficulties in travelling to the practice.
- Patients with multiple conditions were usually reviewed in one appointment to avoid them having to make several visits to the practice.
- The practice provided a range of services on site for patients with a long-term condition. This included spirometry (to assess breathing difficulties); foot checks for patients with diabetes; and insulin initiation.
- Specialist nurses provided input and advice to the practice for patients with more complex needs. This also supported the ongoing development of the practice nursing team who had undertaken additional training to enhance their knowledge and skills in treating patients with a long-term condition.

Families, children and young people

Good

- The community health visitor and midwife attended a meeting with practice clinicians once a month to discuss any child safeguarding concerns.
- Child protection alerts were used on the clinical system to ensure clinicians were able to actively monitor any concerns related to any vulnerable children.
- Childhood immunisation rates for the vaccinations given to infants aged five and below ranged from 95.2% to 100% (local average 95.2% to 98.9%).
- Requests for child consultations were prioritised, and children under five years of age would always be offered an appointment on the same day.
- Appointments were available outside of school hours
- The practice provided family planning services to fit and remove intrauterine devices (coils) and implants, and clinicians provided advice on all aspects of contraception.
- A separate baby care room provided nappy changing facilities, and privacy for mothers who wished to breastfeed on site.

Summary of findings

Working age people (including those recently retired and students)

Good

- The practice offered on-line booking for appointments and requests for repeat prescriptions. The practice provided electronic prescribing so that patients on repeat medicines could collect them directly from their preferred pharmacy.
- Extended hours' GP consultations were available at the main site. Early morning and evening appointments were available on one day each week to accommodate the needs of working people.
- The practice held 'drop-in' blood clinics to offer more flexible access for patients. However, bookable appointments were also available if patients preferred this option.
- The practice promoted health screening programmes to promote patients' wellbeing. For example, screening uptake for cervical, bowel and breast cancer was in line with local and national averages.
- The practice offered health checks for new patients and NHS health checks for patients aged 40-74.
- The practice referred patients to health trainer sessions for support and advice including weight management, smoking cessation, and alcohol consumption.

People whose circumstances may make them vulnerable

Good

- The practice had undertaken an annual health review in the last 12 months for 90% of eligible patients with a learning disability.
- The practice provided care to a home for people with a learning disability, and a named GP visited people on a fortnightly basis.
- Longer appointments (often on an opportunistic basis) and home visits were offered to vulnerable patients when required.
- The practice provided high quality end of life care. Patients with palliative care needs were reviewed at regular multi-disciplinary team meetings, and had supporting care plans in place. A member of the district nursing team informed us that the GPs were caring and were responsive to their patients' needs.
- Staff had received adult safeguarding training and were aware how to report any concerns relating to vulnerable patients.
- Homeless patients were able to register with the practice.
- The YMCA was moving into the shared building on the day of our inspection. The practice was considering how they might be able to support individuals who accessed the YMCA, for example, with work experience opportunities.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

- The practice achieved 96.5% for mental health related indicators in QOF, which was 1.6% below the CCG average and 3.7% above the national average. This was achieved with lower levels of exception reporting.
- 93% of patients with poor mental health had a documented care plan during 2014-15. This was in line with the CCG average of 93.3% and slightly above the national average of 88.3%. This was achieved with much lower exception reporting at 5.4% (local 17.4%; national 12.6%).
- The practice sought expert advice to support patients with complex needs when this was required. For example, a consultant based in Sheffield had visited the practice to discuss a patient's care, and a psychiatrist attended the multi-disciplinary team meeting by invitation.
- The practice had developed an approach with patients who regularly accessed health services to call them for regular reviews with the same GP to manage their condition, thereby preventing a build-up of anxiety and subsequent chaotic behaviour.
- 82.7% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months.
- Staff had undertaken 'dementia friends' training, to enhance their knowledge of support available to patients with dementia and their carers. Members of the PPG had also participated within the training.
- A representative from the community mental health team usually attended multi-disciplinary meetings to review and discuss any patients with ongoing mental health needs.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016. The results showed the practice was generally performing in line with local and national averages. A total of 244 survey forms were distributed and 113 were returned, which was a 46% completion rate of those invited to participate and represented approximately 0.8% of the registered practice population.

- 56% of patients found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 80% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 88% and a national average of 85%.
- 61% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 86% of patients found the receptionists at this surgery helpful compared to a CCG average of 89% and a national average of 87%.
- 68% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 71% and a national average of 65%.
- 74% of patients said they would recommend this surgery to someone new to the area compared to a CCG average of 84% and a national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 41 comment cards and the majority of patients provided positive comments about the high standards of care received from the whole practice team. Patients commented that they were treated with respect and were listened to with sufficient time to discuss their health needs during consultations. However, nine cards included negative feedback relating to the appointment system, and poor experience with regards to their interactions with the reception team.

We spoke with 12 patients during the inspection who reported a high level of satisfaction regarding their consultations, stating that they were provided with sufficient time and that they were treated as individuals. However, the majority of these patients stated that they were dissatisfied with the long waits for a routine GP appointment.

Ashgate Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.**The team included a GP specialist advisor, a nurse specialist advisor, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service

Background to Ashgate Medical Practice

Ashgate Medical Practice provides care to approximately 14,200 patients from three sites in the Chesterfield area of North East Derbyshire. The practice serves a mainly urban population but also has some patients within a semi-rural location on the edge of the Peak District national park. We visited the main site at Ashgate Manor for the inspection but there are also two branch sites:

- Holme Hall Surgery, Wardgate Way, Chesterfield. S40 4SL.
- Whittington Medical Centre, High Street, Old Whittington, Chesterfield. S41 9JZ.

The practice is run by the Chesterfield Medical Partnership and the surgery provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The practice operates from a new multi-occupancy purpose-built detached building, constructed in 2013.

The practice is run by a partnership of five GPs (three males and two females) and a sixth female partner who is also the practice director. The partners employ five salaried GPs (three female and two males).

The nursing team comprises of four nurse practitioners, three practice nurses, and three health care assistants. The partnership also directly employs a full-time community matron. The clinical team is supported by a practice director and a practice manager, with a team of 24 secretarial, administrative and reception staff. The practice also employs four housekeeping staff.

The practice received training status in July 2016 and GP registrars will commence placements on site by autumn 2016. It is also a teaching practice and accommodates placements for medical students, with plans in place to support nursing student placements next year.

The registered practice population are predominantly of white British background, with 2.6% of patients recorded as being of non-white ethnicity. The practice is ranked in the fifth more deprived decile for deprivation status with a deprivation score (2015) of 24.5 (the local average is 18; England average is 21.8). The practice age profile demonstrates higher numbers of patients aged 45 and over. For example 20.6% of the practice population are aged 65 and above, which is comparable to the CCG average of 21.7%, and slightly above the national average of 17.1%. The practice has slightly less numbers of patients aged below 45 compared with national figures.

The practice's main site at Ashgate Manor opens from 8am until 6.30pm Monday to Friday. The practice closes on one Wednesday afternoon each month for staff training. Extended hours opening is available at Ashgate Manor on a Thursday morning from 7am and on Tuesday evenings until 8.30pm. The branch site at Whittington also offers early morning phlebotomy appointments on a Thursday morning from 7am.

Detailed findings

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed patients are directed to Derbyshire Health United (DHU) via the 111 service. The 111 service and the out-of-hours consultation facility for Chesterfield are located within the same building, and this has been beneficial in establishing good communication with the practice.

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

We carried out an announced inspection on 31 August 2016 and during our inspection:

- We spoke with staff including GPs, the business manager and practice manager, representatives of the nursing team, the pharmacist, and members of the reception and administrative team. In addition, we spoke with representatives from two local care homes, the health visitor, and a representative of the district nursing team regarding their experience of working with the practice team. We also spoke with 12 patients who used the service, and two members of the practice patient participation group.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 41 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record and learning

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

- A form was available to report clinical and significant incidents and this was readily accessible to staff. In addition, the practice had adopted an additional template from a neighbouring practice for the reporting of lower level incidents, known as "learning opportunities to share" (LOTS). LOTS were non-clinical incidents and intended to encourage reporting at all levels and also to create ownership by the member of staff who completed the form. They would usually present the issue at the administration team's monthly meeting.
- Incidents were reviewed to determine the level of risk and actions were taken immediately when required. The practice carried out an analysis of all their significant events and shared any wider learning for the team at staff meetings which were held monthly.
- The practice had tabled six monthly incident trend analysis into their staff meetings to commence a review of any similar themes being reported. This would enable the practice to be more proactive in reviewing any recurrent or emerging issues and to take appropriate action to address this.
- We saw that incidents forms were completed appropriately with evidence of any agreed actions being completed.
- The practice manager had undertaken training in leading improvement in safety and quality, and there was a GP clinical lead for significant events, whose role was to provide additional knowledge.
- When there were unintended or unexpected safety incidents, people received support, information, an apology, and were told about any actions taken to prevent the same thing happening again. This indicated the practice's compliance with the duty of candour.

A total of 40 significant events had been recorded by the practice team over the preceding 17 month period. Learning points arising out of investigations into significant events were identified to improve safety and patient experience in the practice. For example, the practice discovered that a visual and audible screen in reception announcing appointments would display and transmit the full textual information recorded within the appointment schedule. This was discovered when a patient was called in to see the doctor along with the confidential detail of the procedure they were attending for. The practice took immediate action to amend their appointment schedule to ensure only the patient's name was recorded, and no additional information. The patient received an apology and explanation for this error.

The practice had a policy and a clear process to review alerts received via the Medicines Health and Regulatory Authority (MHRA). When these raised concerns about specific medicines, computer searches were undertaken to identify which patients may be affected. Effective action was then taken by clinicians to ensure patients were safe, for example, by reviewing their prescribed medicines. This process was largely co-ordinated by the independent pharmacist and CCG's medicine management technician.

Overview of safety systems and processes

The practice had systems and procedures in place to keep people safe and safeguard them from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to staff. Practice safeguarding policies were accessible and up-to date. Alerts were used on the practice clinical system to identify any patients deemed to be at potential risk of abuse or harm. There was a lead GP for safeguarding both children and adults, who had received training at the appropriate level (level 3) in support of the roles. The designated safeguarding lead GP was also a child safeguarding lead at the local hospital and this brought additional knowledge and experience spanning the primary and secondary care sectors. The community health visitor and midwife attended a monthly meeting with the lead GP for child safeguarding to discuss any child safeguarding concerns. Minutes of the meeting were documented and circulated to clinicians. The health visitor informed us that they had a good relationship with the practice and that issues were discussed and acted upon as required to keep children safe. We were provided with an example of when action had been taken by clinicians

to ensure the welfare of vulnerable patients. Practice staff demonstrated they understood their responsibilities and all had received training relevant to their role.

- The practice had a written chaperone policy, and staff who acted as chaperones had received either face-to-face or online training to support their role. A notice in the reception and the consulting rooms advised patients that a chaperone could be made available for examinations upon request. Staff who were not clinicians wore a badge to identify them as a 'trained chaperone' during the examination. The practice had not undertaken a disclosure and barring check (DBS check) on two staff who were trained to act as a chaperone. A DBS check identifies whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. When this was discussed with the practice, they told us that they would ensure that the staff without a DBS check would cease these duties and they would arrange for appropriate DBS clearance to be obtained immediately.
- We found the practice was tidy and visibly clean. A nurse practitioner was the appointed infection control lead and additional training had been undertaken in support of this role. There were infection control policies in place, which had been reviewed regularly. Most practice staff had received some infection control training, and new staff were directed to complete online infection control training when they commenced their role. Annual infection control audits were undertaken, and we saw evidence that recommendations had been made as a result of this, which were being formalised into an action plan. The practice employed their own housekeeping staff who worked to written schedules of cleaning tasks, and we saw evidence that these checks were being recorded, and arrangements were in place to monitor cleaning standards. Documentation of clinical waste consignment notes was available and the clinical waste procedure in place was appropriate and robust.
- We saw evidence that clinical staff had received vaccinations to protect them against hepatitis B. Non-clinical staff had been offered this vaccination, and most staff had received this.
- We reviewed three staff files and found that recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.
- The practice had a robust system to manage incoming correspondence to ensure that any actions, such as a change to a patient's medicines, were completed promptly. The practice director sorted the GPs incoming mail, and the health care assistant did the same for the nursing team to filter information that did not need to be reviewed directly by a GP or nurse to protect their clinical time. The practice told us this had reduced the mail being sent to clinicians to action by up to 60-70%. However, all correspondence relating to children, mental health and cancer, or with any clinical implications, would always be reviewed by a GP or nurse.

Medicines management

The arrangements for managing medicines in the practice were mostly safe although we did identify some areas that required greater oversight.

- Blank prescription forms and pads were securely stored, but the recording of the distribution of prescriptions within the practice was not always robust or in alignment with the practice policy. Systems for the destruction of prescriptions for GPs who no longer worked for the practice required strengthening. Monthly medicines stock checks including expiry dates were undertaken, although we did find that two emergency medicines within a child immunisations box were out-of-date. In addition, a medicine had an expiry date written on the outside of its storage box which did not correspond with the date on the actual medicine. The practice took immediate action to rectify these issues and updated their procedures to prevent any recurrence.
- Signed and up-to-date Patient Group Directions were in place to allow nurses to administer medicines in line with legislation, and healthcare assistants administered medicines against a patient specific prescription or direction from a prescriber. Nurse prescribers and the independent pharmacist received support and mentorship from GPs.
- We observed systems to regularly monitor patients prescribed high-risk medicines.

Good

Are services safe?

- We were informed of a process to monitor any uncollected prescriptions and to follow this up with the patients concerned. Uncollected prescriptions for controlled drugs were destroyed after one month and logged on the computer system, and for other prescriptions this was done every three months.
- The management of medicines within vaccine refrigerators was appropriate and well-managed, although there was no cold-chain policy available. We were informed that the practice were aware of this and were provided with an appropriate draft policy following our inspection. The policy required implementation supported by staff training and regular monitoring to ensure it was adhered to.

Monitoring risks to patients and staff

- There was a health and safety policy available, and the practice fulfilled their legal duty to display the Health and Safety Executive's approved law poster in a staff area. There were risk assessments in place to monitor safety of the premises such as the control of substances hazardous to health. Some risk assessments were in place but were not being used proactively to identify and manage new or emerging risks, however the practice informed us that they would keep this under review at regular staff meetings.
- The practice was a tenant within a multi-occupancy building, and this had some complexities with regards general site management issues. We saw that the practice had made efforts to engage with the site landlord and had taken the initiative to organise meetings with other services in the building to discuss issues that impacted upon them all. However, there had been limited uptake from others occupiers but the practice continued to try and develop this arrangement. There was a designated team leader for site-related issues.
- The practice had a documented fire safety risk assessment in place. Staff had received regular fire training, and the practice undertook annual evacuations to ensure staff were aware of the procedure to follow in the event of a fire. As the practice covered two floors, there was a system for staff to act as fire marshals and their role was aided by accessible and laminated quick reference cards to provide a check-list of duties to be completed. We found that fire-fighting equipment, alarms and emergency lighting were regularly maintained.
- A formal risk assessment for legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings) had been completed by the landlord. Procedures were in place to ensure the regular running of infrequently used water outlets. We were provided with evidence that the practice had discussed the monitoring of their legionella action plan with the landlord, who had responded to confirm that they accepted this responsibility for the building.
- All electrical equipment was regularly inspected to ensure it was safe to use, and medical equipment was calibrated and checked to ensure it was working effectively. We saw certification that this had been completed by external contractors in the last 12 months.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. We were provided with examples of how the team worked flexibly to ensure adequate cover was available at all times.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms and patient areas, which alerted staff to any emergency.
- There was a first aid kit and accident book available.
- All staff had received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were accessible to staff in a secure area of the practice and all staff knew of their location.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan was reviewed regularly with the most recent update in August 2016. A copy of the plan was kept off site in case access to the premises was not possible. Contingency arrangements were in place to relocate services to the other branch sites, should this be required.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, and local guidance, for example, in relation to prescribing. Clinical guidelines were accessible via the practice computer system. Regular clinical meetings offered the opportunity to review and discuss any new guidance.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 92.8% of the total number of points available. This had been achieved with a low level of exception reporting rates at 7.6%, compared to a local average of 11% and national average of 9.2%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

QOF data from 2014-15 showed:

- Performance for diabetes related indicators was 78.1% which was below the CCG average of 96.7% and above the national average of 89.2%. Exception reporting for diabetes related indicators at 9.2% was below the CCG average of 13.4%, and the national average of 10.8%.
- 75.6% of patients with hypertension had received a regular blood pressure test which was below the CCG average of 85.3%, and the national average of 83.6%.
- The practice achieved 100% for asthma which was approximately 2.5% higher than local and national averages. Exception reporting was lower at 4% (local 9.6%; national 6.8%).

The practice was aware of the areas in which achievement had been below the local average. This had been partly due to the practice merger and the use of different processes. The issue had been addressed and a template had been designed to strengthen the recording of data. This had also been discussed at clinical meetings where actions had been agreed such as highlighting the use of the template, instead of using free text to document the consultation. The practice provided data for 2015-16 (which remained subject to external verification) demonstrating an increase in the overall QOF achievement to 96.5%. The performance for diabetes related indicators had risen to 90.3%, and hypertension had achieved 100%.

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

- There had been 15 clinical audits undertaken in the last year. Six of these were completed full cycle clinical audits where changes were implemented and monitored with positive outcomes for patients. We reviewed a full cycle audit on prescribing recommended medicines for patients with osteoporosis. This demonstrated an improvement in the prescribing of bone-sparing agents in line with guidance to prevent the onset of osteoporosis.
- The practice worked with a CCG medicines management technician and carried out medicines audits to ensure prescribing was cost effective, and adhered to local guidance.
- The practice participated in local benchmarking activities. For example, the practice undertook a review of data provided by their CCG including referral rates and hospital admissions.
- One GP partner was actively involved in undertaking research projects. The GP was supported by two research nurses and two research co-ordinators in the practice as part of this role, and another partner provided some additional support. The GP had received national recognition for their research including an award within the last year, for 10 years of highly respected work from the National Institute of Health Research. This was awarded, in that year, to only five clinicians in the country. The research work had impacted on patient care on a wider basis than solely for practice patients. For example, a study had been undertaken regarding the use of different anticoagulation medicines (used to control the clotting of blood) for patients with atrial fibrillation (an irregular heart rhythm). This resulted in the use of a new and safer type of medicine being introduced in other practices to treat patients with this condition. In turn, this gave the practice a head start in using this particular type of medicine with positive outcomes for patients.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

- The practice had established an effective skill mix within their team. Nurse practitioners and a community matron complimented the work of the GPs, and provided autonomy for these nurses to see patients with a wider range of presentations. The nurse practitioners were able to prescribe and see patients with minor illnesses and minor injuries.
- The practice employed a community pharmacist for four days each week as part of a pilot project to place pharmacists within primary care to support practices with medicines issues. The pharmacist was able to prescribe some medicines directly, and had also recently undertaken additional training to be able to see and treat patients with minor illnesses. This gave additional capacity for patient appointments.
- The practice had developed induction programmes for all newly appointed staff. This incorporated relevant topics for new staff, and we saw evidence of completed induction programmes in staff files. Staff informed us they were well-supported when they commenced their role and were provided with time to shadow colleagues to understand the job and any associated tasks more fully. An induction pack was available for GP locums.
- The practice ensured role-specific training with updates was undertaken for relevant staff e.g. administering vaccinations and taking samples for the cervical screening programme.
- There was encouragement and a commitment to develop and support staff to enhance their skills and knowledge. For example, a member of the administration team had been supported to undertake a year-long secondment as the practice's care co-ordinator.
- Staff had received an appraisal within the last 12 months. We spoke to members of the team who informed us of how learning opportunities had been discussed during their appraisal and supported by the practice. For example, the practice manager had been supported to undertake Caldicott training to enhance the practice approach to patient confidentiality. The practice would assist with funding for training if the training requested was relevant to the role and in alignment with business objectives.
- Staff had access to and made use of e-learning training modules and in-house training, and had received mandatory training that included safeguarding, fire safety awareness, and basic life support. The practice had protected learning time on one afternoon each month, and in-house training was arranged for the practice team. This had included speakers attending the practice to deliver training on autism, dementia and Parkinson's disease to improve the knowledge and awareness of staff. GPs attended training events organised by their CCG on some of these months.
- Nurses received support for their roles. For example, the nurse practitioners were able to access mentorship and advice from GPs in respect of their roles, and particularly in relation to their independent prescribing status. The independent pharmacist had been appointed a named GP clinical supervisor to ensure the role was supported and monitored for safe and effective quality standards.

Coordinating patient care and information sharing.

- The information needed to plan and deliver care and treatment was available to clinicians in a timely and accessible way through the practice's electronic patient record system. This included care plans, medical records, and investigation and test results. We viewed examples of care plans which were all appropriate.
- The practice team worked collaboratively with other health and social care professionals to assess the range and complexity of patients' needs, and plan ongoing care and treatment. Fortnightly multi-disciplinary meetings were held between practice clinicians and representatives from a wide range of professionals including district nurses, representatives from the local hospice, social services, the community mental health team, and the community rehabilitation team. The meetings focused upon vulnerable patients (including those at high risk of hospital admission); patients with end of life needs; and patients in care homes. Minutes were produced from these meetings which were sent to all attendees and these were also made available electronically to the practice team.
- Clinical meetings were held each fortnight and also as part of the protected learning time afternoon each month. The notes from these meetings were extremely brief but the practice had already identified this as an issue and had plans in place to address it.
- Nursing staff held their own meeting once a fortnight and these were documented.
- Newly diagnosed cancer patients were reviewed holistically at monthly clinical meetings to ensure that

Good

Are services effective?

(for example, treatment is effective)

all the necessary care and support required had been arranged, and was appropriate to that person's needs. Any learning was acknowledged to continuously improve the quality of service being provided.

- The practice team met together informally for approximately 30 minutes at 11am each morning. This offered an opportunity to discuss any issues which may have arisen that day, or simply allowed designated time for staff to have a break from their duties and meet with colleagues. Reception staff attended in two shifts to ensure cover for patient enquiries was available. The meeting also provided community staff with easy access to the clinical staff during this time if they wished to discuss any patient concerns. Staff told us this meeting was very useful, particularly as the layout of the practice meant that some staff would not normally see each other as part of their daily working routines.
- The practice worked with their allocated CCG medicines management technician who attended the practice regularly to offer advice and support on prescribing issues. The technician provided the practice with a range of information and advice which they acted on to improve patient safety, for example to review prescribing of specified medicines.

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. Where a patient's mental capacity to consent to care or treatment was unclear, the clinician assessed the patient's capacity and, recorded the outcome of the assessment.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Staff were able to say how this applied in individual cases, and the actions they would take. For example, staff followed national guidelines to assist clinicians in deciding whether or not to give sexual health advice to young people without parental consent.
- Consent was recorded for any invasive procedures including coil fittings and minor surgical procedures.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- The practice referred relevant patients to a health trainer to provide advice on healthier lifestyles, and signposted patients to community based support programmes, including services to help patients stop smoking.

Public Health England data showed the practice's uptake for the cervical screening programme in the 2014-15 period was 82.2%, which was in line with the local CCG average of 81.6%, and slightly above the national average of 76.7%. The practice encouraged patients to attend national screening programmes for bowel and breast cancer screening and uptake was in line with local and national averages.

Childhood immunisation rates for the vaccinations given to children aged up to five years of age were in line with expected averages. The overall childhood immunisation rates for the vaccinations given to under two year olds ranged from 95.5% to 99.2% (local average 95.2% to 98.9%) and five year olds from 95.2% to 100% (local average 96.5% to 99.1%).

The practice provided health checks for new patients and NHS health checks for patients aged 40–74. This service had been temporarily halted due to unforeseen circumstances, but was going to recommence in September 2016 with the arrival of a new health care assistant. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

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

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

- 89% of patients said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 81% of patients said the last GP they spoke to was good at treating them with care and concern which was below the CCG average of 90%, and slightly below the national average of 85%.

Staff at two local care homes covered by the practice informed us that they felt people living there were well-cared for by the practice. They said that the people were treated as individuals and their needs were respected and addressed. However, staff at the home for people with a learning disability said they could not always speak with their named GP when they called the practice, and felt this had some impact on the continuity of care provided.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in decision making about the care and treatment they received, and feedback on the patient comment cards we received aligned with these views.

Results from the national GP patient survey showed results were slightly lower than local and national averages in relation to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 82%.
- 81% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.

Patient and carer support to cope emotionally with care and treatment

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

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 1.3% of the practice list as carers, and identified new carers upon registration. A carer's pack was available and leaflets and posters directed carers to the support services available to them. The practice had appointed two designated 'Carers' Champions' to champion carers' needs, although these roles required more focus upon responding to the specific needs of carers. Carers were encouraged to receive the annual flu vaccination. The practice also invited families and carers of newly diagnosed cancer patients to contact them for support and advice, even though they may be registered with a different GP practice. A representative from the local carers association had recently attended a staff meeting to discuss support for carers.

The practice worked to high quality standards for end of life care to ensure that patient wishes were clear, and that they

Good

Are services caring?

were involved in the planning of their own care. Regular end of life care audits were undertaken to review and continually improve the care for these patients and their carers. The GP would usually call family members or carers further to bereavement to offer condolences and support if required, and the practice also sent a letter to carers or relatives.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG), to secure improvements to services where these were identified. For example, the practice had been selected for the GP Pharmacy Transformation Programme to provide a prescribing community pharmacist within the practice. This offered an alternative approach, for example, in the monitoring of patients taking high risk medicines; conducting medicines reviews such as those patients with a long-term condition; and seeing patients presenting with a minor ailment. This gave better access for patients, and expert advice and support on medicine-related issues.
- The premises were modern and purpose built and were shared with other services including a nursery, an independent pharmacy, and the out-of-hours service, which was beneficial for patients and aided communication with the practice.
- Two branch surgeries were available and patients could attend appointments at any of the three sites.
- An independently managed café was available in the building, located besides the practice. This helped promote links with the community as this facility was available to everyone, and therefore the public could easily access health promotion materials and information.
- The practice provided a phlebotomy service at all three sites. This included a drop-in facility as well as standard appointments. Some patients we spoke with told us they preferred the drop-in clinic as an alternative to booking an appointment.
- The waiting area contained a wide range of information on services and support groups. Notice boards were well-maintained and included relevant health related information.
- A touch screen log in facility was available for patients to book in upon arrival at the surgery. A television screen in the waiting area displayed information for patients and announced appointments.
- The layout of the reception provided a waiting area for patients away from the main desk which promoted confidentiality. A rope barrier was in place at the reception desk to aid confidentiality when patients spoke to the receptionist, and a notice was displayed asking patients to stand back whilst other patients were being seen. In addition, patients could use a private room next to reception if they were distressed or required a private discussion.
- The nurse practitioners provided home visits to some patients with acute health needs. This provided a more holistic review of the patient's needs. These were supported by a handover between the GP and nurse practitioner prior to the visit, and a GP was always available by telephone during the visit. If necessary, the nurse would call out the GP if this was clinically indicated.
- One of the GP partners provided the medical input for a substance misuse shared care clinic which was held each month. This enabled patients to be seen locally in a familiar environment.
- The practice hosted a number of services on site to facilitate better access for patients. This included the Citizens Advice Bureau; the abdominal aortic aneurysm screening programme; podiatry for foot assessments on more complex patients with diabetes; and the Live Life Better Derbyshire service who promoted healthy lifestyles. Patients could book an appointment to see the dietitian, and the alcohol advisory service, on site subject to their individual needs. Support for patient with mental health difficulties was aided by access to a counsellor who would occasionally see patients at the practice.
- Practice patients could self refer to the physiotherapy service. A physiotherapist provided a regular clinic at one of the branch sites.
- Longer appointments could be booked for those patients with more complex needs. Same day appointments were available for children and those patients with medical problems that required them to be seen urgently.
- The practice provided care for people living at two local care homes. We spoke with representatives from each home who informed us that the practice was responsive to people's needs. Named clinicians visited each home every two weeks to review patients, and any urgent requirements were responded to on the day.
- Patients could book appointments and order repeat prescriptions on line. The practice participated in the

Good

Are services responsive to people's needs?

(for example, to feedback?)

electronic prescribing scheme, so that patients could collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.

- The premises provided accessibility for patients in wheelchairs, or those with limited mobility. The entrance had automated doors and an accessible toilet was available. All patient services were accessed on the ground floor. A hearing loop and available.
- Translation services were available for patients whose first language was not English.

Access to the service

The practice's main site at Ashgate Manor opened from 8am until 6.30pm Monday to Friday. Scheduled GP morning appointments times were available throughout most of the day as the GPs worked staggered times, which extended the scope for consultations. The practice closed on one Wednesday afternoon each month for staff training, when calls would be directed to the out-of-hours provider via the 111 service. Extended hours opening was available at the Ashgate Manor site on a Thursday morning from 7am and on Tuesday evenings until 8.30pm (last appointment at 8.15pm).

Results from the national GP patient survey published in July 2016 showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages.

- 56% of patients said they could get through easily to the practice by phone which was significantly below the CCG average of 77%, and the national average of 73%.
- 61% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 39% of patients said they usually got to see or speak to a preferred GP compared against the CCG average of 60%, and a higher national average of 59%.

Patients could book ahead up to four weeks in advance for a GP consultation. On the day of our inspection, we saw that the next available routine GP appointment was available the following day, although we were informed that usually this could be up to two weeks ahead. However, appointments were released each day, and patients had the option to ring back the following day rather than to wait for the next routine appointment. When the appointments released each day had been filled, any urgent requests were triaged by a GP and where appropriate would be offered a telephone consultation or an appointment to see a GP, a nurse practitioner or the pharmacist on the same day or the following day. Some patients we spoke with on the day, and feedback received on a number of comment cards, expressed some dissatisfaction with the appointment system. However, the practice was aware of the issue and was taking actions to address the situation. For example, they were raising awareness on the appropriate use of the appointment system with assistance from their PPG. We heard that as the facility to see other professionals rather than a GP had become embedded, some patients were asking to see a nurse or the pharmacist as their preferred option. The practice intended to formally assess the impact this had on access in the longer term via feedback mechanisms, including the national GP survey.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice director was the designated person who dealt with clinical complaints in the practice, whilst the practice manager was the lead for site, administrative and reception complaints.
- We saw that information was available to help patients understand the complaints system.

We looked at a selection of 42 formal complaints received in the last 13 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. The practice offered to meet with complainants to discuss their concerns whenever appropriate. Complaints were considered at the monthly clinical meeting, and any lessons learnt were shared with the wider team as appropriate. Action was taken as a result to improve the quality of care.

We saw an example of how learning had been undertaken following a complaint which had arisen due to the perceived negative interactions with staff by a patient. The practice had met with the patient and listened to their concerns and agreed an action plan. This led to training

Good

Are services responsive to people's needs?

(for example, to feedback?)

being provided to the practice team to help their understanding of the condition, and this subsequently impacted positively on the relationship between the two parties. This learning had initiated a series of training events for other conditions to enhance staff awareness.

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

- The partners had developed a mission statement that 'each and every patient matters' defining the aim of providing the highest quality care to patients in a responsive, supportive and courteous manner. This was supported by core values including a focus on a patient centred approach; quality service provision by a skilled team; teamwork; and continuous staff development.
- The practice held a partners' meeting each month including the practice manager. An identified lead nurse and lead salaried GP would attend the first part of the meeting to aid communication with clinicians. This meeting focused upon key issues relating to the daily operation of the practice. These meetings were comprehensively documented. In addition, the practice director met regularly with the practice manager to keep ongoing business matters under review.
- The practice had started to develop a five-year forward plan to outline their aspirations for the future. This included alignment with the CCG strategy for 21st century care with joined-up services and with care being provided closer to patient's' homes.
- The practice participated in local meetings with other GP practices to work collaboratively and share best practice. The practice was keen to develop a more integrated approach in dealing with emerging issues, such as the potential demands for seven day opening. As part of this, the practice had formed a local federation with the other Chesterfield GP practices to plan for the future using a more collaborative methodology.
- The practice manager was the current chair of the Chesterfield Practice Managers' Forum which met monthly. This helped to facilitate joint working and the sharing of best practice. A nurse practitioner was the designated CCG lead nurse and was funded for half a day each week by the CCG to promote communications and share best practice.
- The practice worked effectively with their CCG. For example, the practice director, lead nurse and chair of the PPG sat on the CCG's primary care development group.

Governance arrangements

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

- There was a clear team structure in place, and staff were aware of their own roles and responsibilities. GPs had clinical lead areas of responsibility, and acted as an expert resource for their colleagues.
- Systems were mostly in place for identifying, recording and managing risk, and implementing mitigating actions. Some issues were identified regarding the practice's quality monitoring arrangements which lacked robustness, but the practice responded immediately to address these.
- A wide range of practice specific policies were implemented and were available to all staff.
- An understanding of the performance of the practice was maintained. This included analysis and benchmarking of QOF performance, referral rates, and prescribing data. The practice worked with the CCG in their annual review of the quality and performance of the service, and developed actions to address any significant variances that were identified.

Leadership and culture

- The partnership had undergone a turbulent period over the previous five years during which six experienced GPs had either retired or left the practice. In 2013, there was a merger between two practices to form the new configuration across the three sites and the formation of Chesterfield Medical Partnership as the provider organisation. At this time, the main site re-located into the new purpose built accommodation. Throughout this period, the partnership demonstrated resilience and ensured continuity of care for patients and the ongoing development of the practice and their team. Despite a series of more recent personal difficulties that had impacted upon individual staff, sometimes with a wider impact across the team, the partnership had demonstrated they had the experience and capability to run the practice effectively to ensure continuity and the delivery of care for patients.
- Over the previous two years the practice patient population has increased significantly and the practice accommodated this additional demand whilst working to try and minimise disruption to existing registered patients. Their main difficulty had been with patient

Are services well-led?

Good

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

records due to the use of differing computer systems. However, the practice had raised this issue with their CCG in order to access funding for assistance with notes summarising.

- The practice had recently introduced five team leader roles. This was an evolving process and had been implemented to ensure that there was a designated lead for each administrative process to create more consistency. Team leader meetings had recently commenced to support this development.
- Staff told us there was an open culture within the practice and said the partners and practice manager were approachable, and always took the time to listen to all members of staff. Staff told us that they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Support was provided to the branch surgeries as the majority of staff rotated between sites, and reported any concerns back to the practice management.
- Staff told us the practice held monthly practice team meetings. These were held when the practice closed for training on one afternoon each month. This was split into clinical and non-clinical meetings but the whole team came together to discuss issues such as learning from significant events or for training.
- Staff we spoke with told us that the practice was a good place to work, and that the team supported each other to complete tasks. Occasional social events throughout the year helped support a strong team spirit within the practice. A team building event had been arranged for September 2016.
- Staff said they felt respected, valued and supported, by the partners and managers in the practice. We were provided with examples of how staff had been supported to develop within their roles, and how the practice had offered support to the team following the bereavement of a staff member. Staff also said that their personal needs had been accommodated where this had been possible, and described the management as being supportive and understanding. The partners took a flexible approach regarding working hours as this was good for staff and also improved access to services for patients.
- The practice demonstrated they valued their staff via an 'Above and Beyond' scheme. This was used to highlight a staff member who had provided exceptional care to patients or had made a particular contribution to the practice. This was then highlighted at the next staff meeting to acknowledge their work. An example included a staff employee who had spent 25 minutes responding to a patient with complex needs in a highly professional manner. The practice intended to use this event as a learning exercise for other staff to share good practice.

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

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

- The practice had gathered feedback from patients through patient surveys; the NHS Choices website; via complaints received; a patient's comments book; and responses received as part of the Families and Friends Test (FFT). The FFT is a simple feedback card introduced in 2013 to assess how satisfied patients are with the care they received. The practice produced a bi-monthly 'You Said, We Did' news sheet to respond to the most commonly raised issues. This was discussed with the PPG and was displayed within the reception area. This included responses to comments such as parking difficulties and facilities within the waiting area.
- The PPG met monthly, and had a membership of approximately 14 core members who regularly attended meetings which included representation from the practice manager or practice director. The PPG were proactive and made suggestions to improve patient experience. For example, the PPG had been involved in recent consultation events regarding the opening times of the branch sites. The PPG had been involved in the planning of the new building, and had organised market-style health stalls for the 2016 flu campaign. They produced informative newsletters for patients and promoted their work via a dedicated notice board at the practice entrance. Representatives of the PPG also participated in wider meetings including the CCG Primary Care Development Group.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They could propose items for inclusion on the agenda for the monthly team meeting. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

Are services well-led?

Good

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

- The practice had a history of innovative practice and had been the first practice in Chesterfield to introduce the nurse practitioner role. This role was now embedded to the extent that we were told many patients preferred to book appointment directly with the nurse practitioner, rather than with the GP. The practice reviewed the skill mix of their team regularly and looked at new and innovative ways of working. For example, nurse practitioners undertook home visits for some acute presentations with appropriate support and advice being provided by GPs.
- A GP partner who undertook research had national recognition and ensured the practice was at the forefront of new and emerging practice as a consequence. For example, a study into the use of different anticoagulation medicines for patients with atrial fibrillation had resulted in the use of a new and safer type of medicine being introduced widely to treat patients with this condition. The practice was one of the first to use this particular type of medicine as a result with positive outcomes for patients.
- The practice team was forward thinking and actively engaged in schemes to improve outcomes for patients in the area. The practice was part of a pilot practice with NHS England on their project "Unlocking the potential of Unlocking the Potential of Community Pharmacy: A Challenge Fund for Community Pharmacy Transformation". They were one of only six GP pilot sites chosen across the counties of Derbyshire and Nottinghamshire. They were selected to take part within the pilot by a selection process in which they scored highly with regards to their training ambitions, team work ethics, previously established close working relationships with community pharmacists, and their overall ambition for the programme. From September 2015, the practice had a pharmacist working at the practice four days a week supporting an agreed category of patients. The project was awaiting an independent formal evaluation from Nottingham University School of Pharmacy, however, the practice were able to demonstrate themselves that the project had already achieved:
- The pharmacist had made 2,173 patient contacts between September 2015 and April 30 2016, approximately 75% of which were face to face consultations. This had a significant impact in releasing additional GP consultation capacity.
- The pharmacist had completed a university based minor illness course which had increased the range of patients that the pharmacist could see, again contributing to additional capacity for GPs and nurses.
- An improved understanding by patients of their medication, with high levels of patient satisfaction.
- Effective support and advice to practice team staff to enhance patient care and experience.
- The programme had been shortlisted for two national awards in 2016.