

# Village Surgery

## Quality Report

Village Community Medical Centre,  
Derby  
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Date of inspection visit: 5 October 2016  
Date of publication: 06/01/2017

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

### Ratings

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Village Surgery on 5 October 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. Learning outcomes were shared with staff.
- Risks to patients were assessed and well managed. Health and safety precautions had been taken which included checking that equipment was fully working and safe to use and infection prevention and control measures were in place.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.

- Comment cards we received from patients showed that they felt they were treated with compassion, dignity and respect.
- The practice cared for 158 residents in 13 nursing/care homes and worked closely with care staff to provide proactive ongoing care
- The practice collaborated with local practices and worked with Derbyshire Community Health Services(DCHS) to develop the community matron role, and provide a service for patients with multiple long term conditions to be reviewed by a dedicated team on a weekly basis to plan their care.
- The practice worked with the local women's refuge, children's home and a supported living facility for people with a learning disability.
- The practice engaged with two local practices on a project to provide co-ordinated care for frail and elderly people with complex needs who were vulnerable and so at risk of admission to hospital. The practices received funding to support a dedicated GP resource to lead the weekly collaborative meetings with the community team where complex cases were

# Summary of findings

discussed and plans agreed. Analysis had not yet been completed, however, the practice were confident that there had been a reduction in admission rates for this group of patients in the preceding 10 months.

- A reception manager was the appointed practice 'Carers' Champion' to develop the identification and support of carers and had identified 2.3% of the practice list as carers. This has been supported by the local carers connect services who attended the surgery monthly to encourage patients who may be carers to utilise the services available to them.
- A total of 93% of patients with a serious mental health condition had a comprehensive care plan documented in the preceding 12 months. This was slightly higher than CCG and national averages which were 92% and 98% respectively. Exception reporting for this indicator was also slightly lower than CCG and national averages. Recently published data for 2015/16 showed that this figure had increased to 97%.
- The practice supported their local food bank by providing a base for food items to be brought in by the local community. These were then collected by the food bank to distribute locally.
- The practice used audits to drive improvement and had completed 27 audits during the preceding two years.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

- 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.

We saw areas of outstanding practice:

- The practice provided an 'enhanced nursing beds' service to patients at the end of their lives. This enabled patients to be discharged earlier from hospital into an enhanced nursing bed at a local nursing home for a period of up to two weeks. This allowed for the patients condition to be stabilised and symptoms managed prior to going home.
- The practice initiated a recall system where a dedicated administrator identified vulnerable and forgetful patients and provided the list monthly to GPs for those patients whose test or injection was due.
- The practice were committed to providing services closer to home as they believed that their population responded more favourably to this and were more likely to attend for treatment at the practice than in secondary care.

However the providers should

- Continue to review patient satisfaction with access to appointments and to evaluate the impact of the steps taken to address this

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events, and lessons learned were shared throughout the practice at regular meetings. When there were unintended or unexpected safety incidents, patients received a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse and staff had received training relevant to their role. The practice had conducted an audit on their management of safeguarding concerns and found that staff complied with policy and guidelines and were well informed about all aspects of safeguarding
- Risks to patients were assessed and well managed. Infection prevention and control procedures were completed to a satisfactory standard. There were effective systems in place to manage safety alerts, including medicines alerts which were acted upon.
- There was a robust process for managing incoming mail including test results which were acted upon on the same day if required.
- Chaperones had received appropriate checks, had been trained and recorded the name of the chaperone in the patient record
- There were enough staff to keep people safe.

### Are services effective?

The practice is rated as good for providing effective services.

Good



Our findings showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines, and clinicians used these as part of their work.

- Audits and reviews were undertaken and improvements were made to enhance patient care.
- Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

# Summary of findings

- There was evidence of appraisals and personal development plans for staff.
- Staff worked closely with multidisciplinary teams to plan, monitor and deliver appropriate care for patients. The teams included midwives, health visitors, the community matron, district nurses and the mental health team.
- The practice used proactive methods to improve patient outcomes and worked with other local providers to share best practice. For example; they met weekly with two local practices to provide a collaborative approach to managing patients with multiple chronic illnesses, enabling patients to be more involved in their care and more compliant with treatment.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. They had achieved 98% of their available points compared to the CCG average of 97% and the national average of 95%.

## Are services caring?

The practice is rated as good for providing caring services.

- We observed a strong patient-centred culture: Staff were motivated and inspired to offer kind and compassionate care and gave examples of how they always put patients first.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible in the waiting areas.
- The practice maintained excellent relationship with local care and residential homes and many selected the practice as their GP provider for their patients were not initially registered with the practice so that patients could benefit from the service provided to care homes.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. The practice had a dedicated champion who ensured that patient confidentiality was a top priority.

Good



## Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

Outstanding



# Summary of findings

They were aware of the practice 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:

- They worked with the local women's refuge, children's home and a supported living facility for people with a learning disability.
- The practice supported their local food bank by providing a base for food items to be brought in by the local community. These were then collected by the food bank to distribute locally.
- The practice worked closely with other local practices on a collaborative project to improve the care for older people.
- Patients rated the practice lower than others in the local area for access to appointments. In response the practice had implemented additional extended hours, including some catch up time in clinics, and progressed customer services training for receptionists.
- Patients we spoke with told us they were satisfied with the appointment system and said they could make a routine appointment within two weeks. Urgent appointments were always available the same day. Telephone consultations and home visits were also available.
- The practice had good facilities and was well equipped to treat patients and meet their needs. The premises were suitable for patients who were disabled and there were baby changing facilities.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and bi-annual complaints meetings were held to reflect on learning from the preceding year and to ensure that any changes to practice had been embedded.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- The practice had implemented a patient contract which outlined what patients could expect from the practice in terms of services and behaviours, for example; being treated with dignity and respect. The contract also outlined responsibilities of patients with regards to communicating with the practice.

## Are services well-led?

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

Good



# Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it. High standards were promoted and owned by all practice staff and teams worked together across all roles.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice embraced opportunities to develop the practice and improve care.
- The practice were proud to be a learning environment and engaged in mentorship programmes for medical students, nursing students and counselling students. They also worked with organisations to enable NVQs and apprenticeship schemes for staff.
- The practice gathered feedback from patients using new technology, and it had a very engaged patient participation group which influenced practice development.

# Summary of findings

## The six population groups and what we found

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

### Older people

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

Good



- The practice had engaged with two local practices on a project to provide coordinated care for frail and elderly people with complex needs who were vulnerable to admission. 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. An analysis had not yet been completed, however, the practice were confident that there had been a reduction in admission rates for this group of patients in the preceding 10 months and that the requests for home visits had also reduced.
- The practice was responsive to the needs of older people, and offered home visits for housebound patients and urgent appointments for those with enhanced needs.
- Requests for a home visit were triaged by phone initially to ensure that patients were prioritised appropriately, and to see whether additional services may be helpful to the patient prior to the visit.
- The practice GPs made weekly ward round visits to local nursing and residential homes aligned to them and provided an enhanced care package to patients who required palliative care. This was an extended Hospice facility in a Nursing Home setting. Lead GPs work closely with the patients, their relatives and the Nursing Home to support the patient and family to achieve comfortable end of life and their preferred place of death.
- The practice supported 158 patients in nursing and care home and a supported living facility.
- The practice provided some services on site so that patients were able to access these without travelling, these included physiotherapy, counselling, psychiatric consultant, aortic aneurysm testing, podiatry services and a dietitians service.
- The practice liaised closely with the District Nursing team and Community Matron and a care co-ordinator to enable patients to receive coordinated care and be directed to services to assist them in all aspects of their lives to facilitate better health
- The practice worked closely with their in-house pharmacy who also provided a delivery service where required.



# Summary of findings

## 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 patients had a named GP and a structured annual review to check their health and medicines needs were being met.
- Patients at risk of hospital admission were identified as a priority and their needs assessed by a multi-disciplinary team that included a Lead GP, care coordinator, District Nursing teams, Social Services, Community Psychiatric Nurse and voluntary groups where appropriate. Patients and carers were referred directly to a number of different services to enable them to receive a coordinated package of care tailored to their individual needs.
- Performance for diabetes related indicators in 2014/15 was 89% which was 4% below the CCG average and the same as the national average. The practice had identified that a high 'did not attend' (DNA) rate had contributed to their under performance and had implemented an improved recall system managed by the care coordinator. Recently published data for 2015/16 showed that they had improved their performance to 92% which was in line with CCG average and above the national average for this indicator.
- Performance for indicators relating to chronic obstructive pulmonary disease indicators in 2014/15 was 95% which was 3% below the CCG average and the same as the national average. Recently published data for 2015/16 showed that the practice had improved performance and achieved 100% for this indicator.
- Performance for indicators relating to heart failure was 100% which was above both CCG and national averages. Recently published data for 2015/16 showed that this performance had been maintained.
- Longer appointments and home visits were available when needed. Home visits for housebound patients with a long term condition were also provided by a senior nurse with a qualification in chronic disease management.

## Families, children and young people

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

Good



# Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- The practice had direct links with health visitors who regularly attended practice meetings. Immunisation rates were in line with CCG and national averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Performance for providing cervical screening tests for appropriate women was 73%. This was comparable with CCG national averages. Recently published data for 2015/16 showed that performance had increased to 79% for this indicator.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Babies and children were treated as a priority and any parent seeking support during opening hours were able to speak with the on call GP for advice or an appointment was made for the same day.
- The practice were working with the CCG on a project to develop young person's services and to initiate a young person's steering group to assist in developing services that are age appropriate.

## Working age people (including those recently retired and students)

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice used a triage system which allowed patients to speak to a clinician, patients can obtain advice, support, signposting or an appointment with a Health Care Professional within the team
- The practice offered extended hours for three mornings each week commencing at 7am and one evening each week until 8pm

Good



# Summary of findings

- They provided telephone consultation appointments to assist working patients, students and carers.

## People whose circumstances may make them vulnerable

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

Good



- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- The practice offered double appointments for patients with a learning disability and for those who required an interpreter .
- The practice regularly worked with a care coordinator and other health care professionals in the case management of vulnerable patients and assisted them in accessing various support groups and voluntary organisations.
- There was an effective recall system that was managed by a dedicated administrator to ensure that vulnerable patients followed through with their appointments.
- The practice worked with the local women's refuge, children's home and a supported living facility for people with a learning disability.
- The practice supported their local food bank by providing a base for food items to be brought in by the local community. These were then collected by the food bank to distribute locally.
- The practice ensured that there was always a female GP on duty as there was a large number of ethnic minority patients who required to see a female GP.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

## People experiencing poor mental health (including people with dementia)

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

Good



- A total of 95% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is higher than the national average which was 85% and 84% respectively. Their exception reporting rate at 6% was

# Summary of findings

slightly lower than CCG and national averages. Recently published data for 2015/16 showed an achievement of 89%, however, the exception reporting at 3% was significantly lower than CCG and national averages.

- A total of 93% of patients with a mental health condition had a comprehensive care plan documented in the preceding 12 months. This was slightly higher than CCG and national averages which were 92% and 98% respectively. Exception reporting for this indicator was also slightly better than CCG and national averages. Recently published data for 2015/16 showed that this figure had increased to 97%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for their 141 patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice provided a service whereby patients could see a Psychiatric Consultant in-house rather than travelling to hospital. This also enabled GPs the opportunity to discuss individual patients with the consultant so that early decisions could be made.
- Patients with a mental health issue were regularly reviewed and the practice had a dedicated administrator to recall patients who did not attend their appointment. GPs often contacted patients by telephone if they failed to attend their appointment.

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## What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. 283 survey forms were distributed and 119 were returned. This represented a 43% response rate.

- 87% of patients found it easy to get through to this practice by phone compared to the CCG average of 93% and the national average of 73%.
- 56% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 72% and the national average of 76%.
- 73% of patients described the overall experience of this GP practice as good compared to the CCG average of 87% and the national average of 85%.
- 68% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and the national average of 78%.

On the day of our inspection we found that patients comments and views did not align with the survey findings and that patients were extremely positive about all aspects of care and the services they received.

We saw a patient survey conducted by the PPG in 2015 which showed that 91% of patients were happy with the waiting times but that only 55% of patients got a GP appointment at a time when they wanted it and 72% of patients got a nurse appointment when it was convenient. 75% of patients described the receptionists as good or very good. The practice acted on this feedback by implementing additional extended hours, including some catch up time in clinics, and progressing customer services training for receptionists.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards which were all extremely positive about the standard of care received. Patients commented that they had received an excellent service and that the staff were friendly, helpful and very welcoming.

We spoke with 19 patients during the inspection. All 19 patients said they were satisfied with the care they received and thought staff were approachable, committed, professional and extremely caring. Patients told us that GPs and nurses often went the extra mile to help them and that reception staff were always friendly and polite.

## Areas for improvement

### Action the service **SHOULD** take to improve

- Continue to review patient satisfaction with access to appointments and to evaluate the impact of the steps taken to address this

## Outstanding practice

- The practice provided an 'enhanced nursing beds' service to patients at the end of their lives. This enabled patients to be discharged earlier from hospital into an enhanced nursing bed at a local nursing home for a period of up to two weeks. This allowed for the patients condition to be stabilised and symptoms managed prior to going home.
- The practice initiated a recall system where a dedicated administrator identified vulnerable and forgetful patients and provided the list monthly to GPs for those patients whose test or injection was due.

## Summary of findings

- The practice were committed to providing services closer to home as they believed that their population responded more favourably to this and were more likely to attend for treatment at the practice than in secondary care.

# Village Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a second CQC inspector

### Background to Village Surgery

Village Surgery provides general medical services to approximately 11,188 patients, and is run by a partnership of six GPs (four male and two female) and a salaried GP who is female.

As the practice is a training practice, GP Registrars work at the practice throughout the year. (GP Registrars are fully qualified doctors who are receiving additional training to work as a GP)

There is currently one Registrar working at the practice.

The main practice is in Derby with a branch surgery about two miles away in the area of Sinfin. Patients can attend either the main practice or the branch practice.

We did not visit the branch surgery as part of our inspection.

The practice population live in an area of high deprivation, which is the 4th most deprived on the decile scale. Income deprivation affecting children is 4% higher than the CCG and national averages and affects older people by around 9% more than the CCG average.

Around 9% of the practice population are unemployed which is almost double the CCG and national averages, which are both 5%.

The practice demand for people with a chronic illness is around 5% higher than CCG and national averages.

The practice team includes a nurse manager who is also an Advanced Nurse Practitioner (ANP), four practice nurses, one of whom is able to prescribe medicines and two Health Care Assistants (HCA). There are two prescription clerks, a full time practice manager, a reception manager and a number of reception and administrative staff.

The practice holds the General Medical Services (GMS) contract to deliver essential primary care services. The practice is generally open between 8am and 6.30pm Monday to Friday with an early opening time of 7am on Tuesdays, Thursdays and Fridays and a later closing time of 8.30pm on Wednesdays. Appointments are available from 7.15am to 12MD and 2pm to 6.30pm on Tuesdays, Thursdays and Fridays, and from 8.15 to 12MD and 2pm to 6.30pm on Mondays and Wednesdays. Extended evening surgery is available on Wednesdays until 7.40pm.

The main Derby practice is purpose built and houses the community nursing team and other colleagues and also has a pharmacy on site which operates independently of the practice.

The practice does not provide out-of-hours services to the patients registered there. During the evenings and at weekends an out-of-hours service is provided by Derbyshire Health United. Contact is via the NHS 111 telephone number.

### 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

# Detailed findings

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. We carried out an announced visit on 5 October 2016. During our visit we:

- Spoke with a range of staff (GP partners, practice manager, advanced nurse practitioner, nurses, reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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



# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events. There had been 17 events recorded in the preceding 12 months. A summary of the past 12 months demonstrated learning was shared, and when appropriate changes were made to protocols and practice.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available which was completed manually. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. For example; following a needstick injury, they updated their policy to reflect best practice.
- The practice conducted bi-annual meetings to discuss significant events, look at trends and to check whether learning had been imbedded. In addition, significant events were discussed at some practice meetings.

The practice had a process to review and cascade medicines alerts received via the Medicines and Healthcare Regulatory products Agency (MHRA). When this raised concerns about specific medicines, searches were undertaken by the GPs in conjunction with the CCG pharmacist to check individual patients and ensure effective action were taken to ensure they were safe. For example, prescribing an alternative medicine if a concern had been raised about the safety of a particular medicine.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems and processes in place to keep patients safe. For example:

- The practice had suitable arrangements to safeguard children and vulnerable adults from abuse which reflected relevant legislation and local requirements. The GP was the safeguarding lead and had undertaken

level three training for child safeguarding. Staff demonstrated they understood their responsibilities to safeguard patients and all had received training relevant to their role including domestic violence. Records reviewed showed quarterly safeguarding meetings took place where the GPs, health visitor, nurse manager, reception manager and assistant reception manager discussed patients in vulnerable circumstances including children. Additional attached staff were invited where relevant. A system was in place for highlighting vulnerable patients on the practice's computer system to ensure staff were aware of any relevant issues when patients attended appointments.

- Information telling patients that they could ask for a chaperone was visible in the reception area and consultation rooms. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had provided training for all those receptionist who acted in the chaperoning role. The name of the chaperone was recorded in the patient record.
- The practice was maintained by an external company and we found there to be appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was a newly appointed practice nurse as the nominated infection control lead who was able to liaise with the CCG infection control lead. There was an infection control policy in place and staff had received infection control training, for example, training in handwashing and specimen handling. We saw that an audit had been carried out in July 2016 the in conjunction with the CCG infection control lead. The audit identified areas for improvement and we noted that actions recommended had been taken to make improvements. For example; fabric chairs had been replaced with wipeable ones, disposable gloves were stored off work surfaces, two damaged couches had been replaced, and sharps injury information had been made accessible on the walls in each clinical room.
- There were effective arrangements in place for managing incoming mail including test results. These were checked daily by GPs, and where a test result showed an abnormal result, a GP would contact the

## Are services safe?

patient on the same day to discuss or make an appointment for them. Where a GP was sick or on holiday, another GP would check and action those results.

- The practice had implemented a system of proactive recall, whereby a dedicated administrator reviewed a list of patients who had not attended for their scheduled blood test each month. A list was provided for each named GP who contacted their patients or sent an alternative appointment where required. This had resulted in a reduction in the number of significant events relating to late blood tests performed for patients being monitored.
- There were systems in place to ensure results were received for all samples sent for the cervical screening programme. There was a dedicated administrator who followed up on samples sent to ensure that no results were missed.
- Arrangements for managing medicines ensured that patients were kept safe. For example, there was a GP who was the lead for medicines management and worked with the clinical commissioning group (CCG) pharmacist to monitor adherence to protocols relating to prescribing and dispensing. Regular medicines reviews were conducted and actions recommended by the CCG pharmacist were followed up by GPs. The CCG pharmacist also conducted regular searches on medicines and identified patients to GP for medicines reviews. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. We saw evidence to show that patients on high risk medicines were appropriately reviewed.
- The practice had two prescriptions clerks who managed repeat prescriptions with clinical oversight of the GPs, and alerted the lead GP for medicines management where prescriptions were not collected.
- There was a temperature monitoring system in the medicines fridges to ensure that vaccines were stored at the correct temperature, and emergency drugs were in date, and regularly checked.
- The surgery did not carry controlled medicines.
- Blank prescription pads and paper were stored securely and processes were in place to monitor their use which included recording serial numbers.
- Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) were being used by the practice to allow nurses to administer medicines in line with legislation.

- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- The practice had procedures in place to monitor and manage risks to patients and staff safety. There was a health and safety policy available which was accessible to all staff electronically.
- Fire alarms were tested weekly and records kept, and staff told us they knew what to do in the event of a fire. A fire drill exercise had been carried out within the preceding six months.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had processes in place to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a bacterium which can contaminate water systems in buildings). There had been a recent risk assessment and water test for Legionella and a certificate provided.
- Arrangements were in place to plan and monitor staffing levels needed to meet patients' needs. There was a system in place for different staffing groups to ensure that enough staff were on duty. Each staffing group had agreements about the number of staff who could be on leave at the same time to ensure service provision was not adversely affected. GPs would cover other GP's annual leave, and a regular locum GP was utilised where required.

### Arrangements to deal with emergencies and major incidents

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

- There was a panic alarm system in all the consultation and treatment rooms which alerted staff to any emergency.
- Basic life support training was delivered annually and there were emergency equipment available which we found to be in date.

## Are services safe?

- There was a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were kept in a secure area of the practice and all staff knew of their location. The medicines we checked were in date.
- The practice had a comprehensive business continuity plan in place. This covered major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and a paper copy was available at each site.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice routinely used National Institute for Health and Care Excellence (NICE) best practice guidance and other national and locally agreed guidelines and protocols as part of their consultations with patients. They monitored these guidelines through risk assessments, audits and random sample checks of patient records. The practice had systems in place to ensure all clinical staff were kept up to date. They also kept up to date with current practice by using topics such as patient safety alerts and medicines alerts which were discussed at practice meetings and attended local events where development was available.

The practice worked with the CCG pharmacist to provide medicines reviews for patients which had resulted in their prescribing practice to be in line with national prescribing guidelines and had achieved the targets set by the CCG.

### 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 98% of the total number of points available. This was achieved with a clinical exception rate of 11% overall.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for asthma related indicators was 100% which was 1% higher than the CCG average and 3% higher than the national average. However, the exception reporting rate was 17% compared to the CCG average of 10% and the national average of 7%.
- Performance for the 11 indicators relating to diabetes was 89% which was 4% below the CCG average and the same as the national average. Exception reporting rate was 9% compared to the CCG average of 13% and the national average of 11%.

• Performance for mental health related indicators was 100% which was 3% above the CCG average and 7% above the national average. Exception reporting rate was 14% compared to the CCG average of 17% and the national average of 11%.

The practice were aware that their exception reporting rate was higher than average for some indicators and had taken steps to improve this by implementing a system whereby the care coordinator contacted patients with diabetes who did not attend for their appointments and rescheduled their appointment.

Recently published data for 2015/16 showed that the practice had improved their performance for most of their indicators. For example;

- Performance for the 11 indicators relating to diabetes was 92% which was a 3% increase from the preceding year and in line with CCG and national averages.
- Performance for asthma related indicators remained at 100%
- Performance for mental health related indicators remained at 100%

There was evidence of quality improvement including clinical audit. There had been 27 clinical audits completed in the last two years. We looked at two of these in detail where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example;

- Additional support was provided for a nurse conducting cervical smears to enable her to improve her technique and reduce the number of incomplete samples taken.
- An audit of a newly implemented auditory micro-suction procedure was conducted. This showed that no complications were reported and out of 31 procedures carried out over six months, only four not appropriate for inhouse treatment and were referred to hospital. The practice planned to continue monitoring and to extend this service further by providing specialist training for additional clinicians.

### Effective staffing

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

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and

# Are services effective?

## (for example, treatment is effective)

safety and confidentiality. We looked at the records for recently recruited staff and found that an induction checklist had been completed. A comprehensive induction programme was in use for GPs including locum GPs.

- There was an appraisal system in operation at the practice, and staff had received their appraisal in the preceding 12 months.
- Staff were supported to undertake training to meet personal learning needs to develop their roles and enhance the scope of their work. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. Development for non-clinical staff included training specific to personal and individual development. For example, there were a number of staff who were undertaking training in additional roles in order to broaden the skill mix of the team. Nurses were also given time to meet together once every two weeks for a regular nurse meeting and to receive peer support to address their needs for nurse revalidation.
- All staff had received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

### 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 the computer system. This included care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together with other health and social care services to understand and meet the range and complexity of people's needs, and to assess and plan ongoing care and treatment. This included when people moved between services, when they were referred, or after they are discharged from hospital. Where people were admitted to hospital as an emergency, the care coordinator would contact them by phone as soon as they were discharged to check on their welfare and discuss any unmet needs.

The care coordinator was able to arrange for patients to access help and assistance with a range of support

programmes through referral to The Live Life Better Derbyshire programme. This included; exercise programmes, weight management programmes, advice about debt and housing, and smoking cessation support sessions. We saw evidence that multi-disciplinary team meetings took place on a monthly basis incorporating reviews of patients at risk of hospital admission, end of life patients, and those who had complex needs. These meetings included a GP, care coordinator, community health team representatives, (community matron, district nurse, health visitor), social work team and the community mental health team where required. Care plans were routinely reviewed and updated and risks assessed.

### 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. This included patients in care and residential homes and specialist schools aligned to them.
- The process for seeking consent was monitored through auditing patients records.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and had a dedicated administrator who maintained registers; For example:

- Patients receiving end of life care,
- Patients who were also carers,
- those at risk of developing a long-term condition
- those requiring advice on their diet, smoking and alcohol cessation
- those who had a learning disability
- those who had a hearing or visual impairment
- those who had a serious mental health condition

Patients were signposted to the relevant service or the care coordinator. A dietician was available on the premises and

# Are services effective?

(for example, treatment is effective)

smoking cessation advice was available from a local support group. The practice also utilised a recall system (8AZ system) which was initiated by the practice whereby vulnerable patient registers were checked each month and relevant patients were reminded to attend for their test or appointment. The appropriate GP was informed if a vulnerable patient to did not attend for a test at the practice or hospital. (blood tests, urine tests, x-ray or scan)

The practice's uptake for the cervical screening programme for 2015/16 was 79%, which was comparable to the CCG average of 77% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. They were broadly in line with CCG and national averages for breast and bowel cancer screening.

There was a dedicated administrator 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.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 74% to 96% which was comparable with the CCG and national averages of 67% to 97%. Results for five year olds was from 74% to 99% which was comparable to the CCG and national averages of 72% to 98%.

Patients had access to appropriate health assessments and checks which were conducted initially by two health care assistants (HCAs) These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made with nurses and GPs, where abnormalities or risk factors were identified.



# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 13 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They also said that GPs communicated well and staff were approachable and kind.

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

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

- 94% of patients said the GP was good at listening to them compared to the CCG average of 93% and the national average of 89%.
- 95% of patients said the GP gave them enough time compared to the CCG average of 93% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 86% 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%.

- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 76% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.

### Patient and carer support to cope emotionally with care and treatment

## Are services caring?

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.

A reception manager was the appointed practice 'Carers' Champion' to develop the identification and support of carers and had identified 2.3% of the practice list as carers. This has been supported by the local carers connect services who attended the surgery monthly to encourage patients who may be carers to utilise the services available to them. The practice's computer system alerted GPs if a patient was also a carer. Written information in the form of

a carers pack was available to direct carers to the support services available to them and this was included in the new registration pack. For complex and urgent needs, carers were referred to the care coordinator.

The practice worked to provide high quality standards for end of life care and had written care plans in place to ensure that patient wishes were clear, and that they were involved in the planning of their own care. The practice reviewed patient deaths to ensure that optimal care had been delivered and to consider any learning. The practice team proactively contacted relatives following bereavement and sent a condolence card.

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





# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice served a population that was the fourth most deprived on the deprivation scale and much higher than average income deprivation for older people and children than both the CCG and national averages. There was also a high number of patients from different ethnic backgrounds and historically had not accessed health care appropriate to their needs. Because of this, they had configured their services to meet the needs of their population.

For example,

- The GPs and other staff spoke a number of different languages and had recently recruited a receptionist who spoke polish
- A female GP ran a weekly clinic to fit and remove intra-uterine devices. (contraceptive coils)
- The practice provided a monthly gynaecology clinic with a GP who specialised in that area and a practice nurse. Appointments were 30 minutes long and took place in a purpose built minor surgery suite. A range of services were offered which avoided unnecessary referrals to hospital and enabled patients to receive treatment in the community where they were more likely to attend. Patients were also able to receive their consultation and treatment more quickly at the practice than for secondary care.
- A recall system was implemented to ensure patients who required regular changing of gynaecology pessary were monitored and contacted prior to their appointment to remind them.
- The practice held regular clinics at the practice to enable patients to receive care who might not otherwise access care through secondary services. For example; Podiatry, dietary clinics, physiotherapy, cryotherapy clinics and nurse-led family planning clinics. They also held a monthly outpatient clinic with a consultant psychiatrist.
- The practice initiated a recall system where a dedicated administrator identified vulnerable and forgetful patients and provided the list monthly to GPs for those patients whose test or injection was due. The patient was also contacted by letter to remind them to attend. The recall system was also used to remind clinicians about any children -in -need reviews that were due within the next month. This enabled the clinician time to

review each case and take additional actions where required to prepare for the review. Where patients have not attended for a test, injection or review, a letter is sent to the patient and they are contacted by telephone if required. The relevant clinician is informed, and where a patient continues to not respond or attend, this is escalated to the practice manager for further investigation and action.

- Patients who did not attend (DNA) for their diabetes checks were closely monitored by the care coordinator. A record was kept of appointment letters, DNAs, prescription requests and contacts with the surgery. The care coordinator contacted relevant patients to explore their reasons for not attending and liaised with appropriate clinical staff or hospital diabetic clinic to resolve the problem where possible.
- The practice booked a double appointment for patients who needed an interpreter.

In addition to adjusting its services to meet the needs of its diverse ethnic population, the practice also responded to the needs of other patients, for example;

- The practice provided an 'enhanced nursing beds' service to patients at the end of their lives. This enabled patients to be discharged earlier from hospital into an enhanced nursing bed at a local nursing home for a period of up to two weeks. This allowed for the patients condition to be stabilised and symptoms managed prior to going home.
- The practice had 13 care and residential homes aligned to them with a total of 158 patients. The lead GP made weekly ward rounds for the larger homes, had close communications with all homes and encouraged regular clinical observations at the homes to facilitate monitoring of patients with actual or potential health problems.
- The practice looked after 141 patients with dementia and worked closely with the multi-disciplinary team and care coordinator to provide appropriate care and support for patients and their carers.
- They worked closely with a local childrens home and a womens refuge to provide supportive services.
- The practice were committed to providing services closer to home as they believed that their population responded more favourably to this and were more likely to attend for treatment at the practice than in secondary care. This included ethnic minority groups and vulnerable groups, but was also available to any patient



# Are services responsive to people's needs?

## (for example, to feedback?)

who wanted this. Services included; Ear Nose and Throat clinics (ENT), aural toilet and aural micro-suction treatment, vasectomy service, minor surgical procedures, and a 'walk-in' blood testing service.

- Following a very challenging situation, the practice implemented a 'patient contract' to be used in challenging situations with patients. This enables the patient to understand individual expectations and agree behaviours of patients and practice staff during a consultation. The contract also identifies areas of support required for the patient and enables the practice to safely manage the patient's health needs.
- The practice provided flu vaccinations and health reviews for the high number of housebound patients.
- They worked with community pharmacist to ensure that prescribing was appropriate. There was a delivery service for housebound and older patients.
- Appointment times were extended as a result of patient feedback
- A care coordinator was recruited to coordinate care for vulnerable patients and to manage a recall system to improve attendance
- As a result of patient feedback regarding access to appointments, the practice had implemented a triage system to manage on-the-day demand for appointments. This was provided by an advanced nurse practitioner (ANP).
- The practice had introduced a policy to see all children under 5 or to provide advice for parents on the day they called. This had resulted in a reduction in attendance at the local accident and emergency department. (A&E) from 10 per 1,000 children to 7 per 1,000 over the preceding two years. This is now in line with CCG average.
- The waiting area contained a wide range of information on services and support groups.
- The layout of reception helped to maintain patient confidentiality. A separate room was usually available for private and sensitive discussions.
- There was a phlebotomy service that enabled patients to receive this on the day of their GP or nurse appointment and was available to patients as a 'walk-in' service.
- The health visitor provided a child health clinic at the practice.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.

- The premises provided suitable entrance doors for patients in wheelchairs, or those with limited mobility. Services were provided over two floors, and a lift was provided. There was a disabled toilet available for disabled patients and a hearing loop was available for patients who had hearing difficulties. The practice provided some higher chairs for patients who had difficulty in standing from a low seat.
- Translation services were available for patients whose first language was not English and many of the GPs and staff spoke different languages.
- There were disabled facilities, a hearing loop and translation services available.
- The practice had implemented a patient contract which outlined what patients could expect from the practice in terms of services and behaviours, for example; being treated with dignity and respect. The contract also outlined responsibilities of patients with regards to communicating with the practice. The purpose of the contract was to engage patients fully in their care and to make patients aware of the consequences of using abusive and threatening behaviour towards staff.

### Access to the service

The practice is open between 8am and 6.30pm Monday to Friday with an early opening time of 7am on Tuesdays, Thursdays and Fridays and a later closing time of 8.30pm on Wednesdays. Appointments are available from 7.15am to 12pm and 2pm to 6.30pm on Tuesdays, Thursdays and Fridays, and from 8.15 to 12MD and 2pm to 6.30pm on Mondays and Wednesdays. Extended evening surgery is available on Wednesdays until 7.40pm.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

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

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and the national average of 78%.
- 58% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 73%.



# Are services responsive to people's needs?

## (for example, to feedback?)

The practice told us that they were aware of the challenges facing patients to get through to the practice by phone and had implemented a plan to resolve it. They had;

- agreed a protocol with reception staff that enabled four calls to be taken at a time using an override extension.
- amended the rotas so that additional staff were available at the busiest times,
- arranged for a call recording facility so that staff training could be carried out on call time management.
- changed the salutation /introduction so that unnecessary dialogue was reduced in order to take patient details quickly whilst still maintaining a rapport, and enabling more calls to be taken quickly.

They had liaised with the PPG who had agreed to conduct a further patient survey in January 2017 to see whether the plan had improved phone access.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice used a triage system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.

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

### Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that comprehensive information was available to help patients understand the complaints system. For example; there was a poster displayed in the waiting areas.

We looked at 34 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints, and action was taken to as a result to improve the quality of care. Verbal complaints were logged and these were responded to by the reception managers and the practice manager.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision and purpose to deliver high quality care in a friendly, caring and professional manner. We saw that all staff took an active role in ensuring provision of a high level of service on a daily basis and we observed staff behaving in a kind, considerate and professional manner. The practice had a strategy and supporting business plans which reflected the vision and values of the practice. The plans included;

- A resourcing and recruitment plan
- Resilience planning
- Transformation into a 'learning environment'
- A commitment to developing staff, including use of apprenticeships.
- Flexible working across roles
- Working with student nurses, medical students and local sixth form students.
- Collaborative working with two local practices to enhance care for older people.

The practice had a mission statement which staff knew about and understood the values which included delivery of high quality care and promote good outcomes for patients. Staff also spoke about the practice's value of working together as a team to achieve their goals.

The practice embraced opportunities to develop the practice and improve patient care. For example;

- They had engaged with two local practices on a project to provide coordinated care for frail and elderly people with complex needs who were vulnerable to admission. 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. Outcomes will be confirmed later this year, however, the practice were confident that there had been a reduction in admission rates for this group of patients in the preceding 10 months.
- They funded training for a senior nurse to upskill to Advanced Nurse Practitioner to provide triage services and chronic disease management for patients which freed up time for GPs to focus on more complex cases.

- They encouraged medical students, student nurses and student counsellors to work under supervision at the practice to enable GPs and nurses to utilise their mentorship skills and to bring additional skills to the practice.

### Governance arrangements

The practice had an overarching 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 staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented, regularly reviewed and updated and were available to all staff electronically.
- The practice engaged with their CCG, and attended locality meetings and the practice managers' forum and nurse forum to work collaboratively and share best practice.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There was a robust meeting structure in place that allowed for lessons to be learned and shared following significant events and complaints.
- A comprehensive understanding of the performance of the practice was maintained.
- Clinical and internal audit was used to monitor quality and to make improvements.

### Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff. Some staff gave examples of how they had been supported during difficult personal circumstances.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support and training for all staff on communicating with

# Are services well-led?

Good 

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

patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held regular team meetings.
- 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.
- There was time allocated for staff to conduct administrative duties and a quarterly QUEST session was held for all staff to receive development. Quest speakers were invited to speak on a number of topics.
- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

## 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 the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, they had recently been involved in drafting a 'did not attend' (DNA) letter for patients. They also produce a PPG newsletter three times each year.
- The practice had gathered feedback from staff through: an annual staff survey, through staff away days and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example; they were working with two other practices to improve health outcomes for older people. They had incorporated a learning ethos across the practice and embraced opportunities for developing staff utilising such schemes as the apprenticeship schemes and NVQs. They had also accessed funding from their local university to host 12 month placements for student nurses.