Wellbrook Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	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 Wellbrook Medical Centre on 20 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led, services. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect.
- Patients we spoke with told us they were satisfied with their level of involvement in or making informed decisions about their treatment. However data from the National GP patient survey 2015 suggested this was slightly below local and national averages.
- Information about services and how to complain was available and easy to understand.
- 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.

However there were areas of practice where the provider should make improvements.

The provider should:

Summary of findings

- Consider all opportunities to ensure patients feel involved in agreeing and making informed decisions about their care.
- Update the lone worker policy to ensure support is available at weekends

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

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. We saw that robust systems were in place to support this. Lessons learned were communicated to all staff to support improvement.

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patient's safety were assessed and well managed including those relating to fire, health and safety and environment.

Medicines and prescribing were well managed and the practice had effective procedures to control the risk and spread of infection. There were enough suitably well trained and supported staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above local and national averages. Guidance from the National Institute for Health and Care Excellence was communicated to all staff and used to assess patients' needs and ensure care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

The quality and effectiveness of care was regularly reviewed and benchmarked against local and national standards. Where improvements were identified, robust action plans were implemented.

Staff had received training appropriate to their roles and any further training to improve staff skills and improve patient outcomes was provided for example near patient testing of INR. The international normalised ratio (INR) is a laboratory measurement of how long it takes blood to form a clot. It is used to ensure patients receiving anti coagulation medicines such as warfarin are receiving the correct dose of the medicine. We saw evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients we spoke with and information we reviewed showed that patients were happy with the care and treatment they received. Although the National GP Patient survey data suggested that

Summary of findings

patients did not always feel involved in planning their care, this did not adversely affect patient satisfaction. Patients said they were treated with compassion, dignity, respect and kindness. Information to help patients understand the services available was accessible and easy to understand. We saw that staff protected patients confidentiality at all times and that robust systems were in place across the practice to maintain this.

Additional support was available to carers of patients at the practice and patients told us they welcomed the emotional support they received from practice staff.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It 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. Although patients were not always satisfied with access to appointments, we saw that the practice had developed action plans to address this which showed some improvements had been made.

The practice identified patients with additional support needs and developed ways to ensure they were able to access the service, for example, joint visits with specialists and support workers to patients with Huntington's disease and teenage vaccination clinics held outside school times.

The practice had good facilities and was well equipped to treat patients and meet their needs. All patient areas were accessible for patients in wheelchairs and those with reduced mobility. Information about how to complain was clear and well publicised. Evidence showed that the practice responded quickly to complaints and feedback and learning was always shared with staff and other stakeholders.

Are services well-led?

Good

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

It had a clear vision and strategy which had been shared with all staff members. All the staff we spoke with were aware of and understood the vision and their responsibilities in relation to this.

A clear leadership structure was in place and staff felt supported by their colleagues and management. Staff had received inductions, regular performance reviews and additional training. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to

Summary of findings

monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The Patient Participation Group (PPG) was active and worked with the practice to improve the service for other patients.

Systems used to monitor quality were effective with improvements shown in performance against national and local targets such as Quality and Outcomes Framework QOF. QOF is a national recording system used to monitor the performance of GP services in a number of areas.

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 is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people such as rheumatoid arthritis, osteoporosis and coronary heart failure. The practice had achieved 100% of the available points in all of these areas which was above both the CCG and National averages.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and care homes and avoiding unplanned admissions. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice supported four care homes in the area each of which had a designated GP which improved communication and continuity of care. Feedback from care home staff showed they were very satisfied with the service they received.

People with long term conditions

Good

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

Nursing staff had lead roles in chronic disease management and had received additional training to do so. Patients at risk of hospital admission were identified and seen as a priority and longer appointments and home visits were available when needed. Patients with long term conditions were offered a single appointment annual review to check that their health and medication needs were being met, rather than attending repeat appointments. QOF data showed the practice consistently performed well above the CCG and England average in relation to indicators in respect of long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease. They achieved 100% of the available points in all of these areas which was above the local CCG and England average.

Patients who had more complex needs or whose condition was life limiting were regularly discussed at multi-disciplinary team meetings and robust care plans put in place

Families, children and young people

Good

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

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The practice had worked with other health agencies in a targeted programme to ensure all children received the required immunisations. As a result immunisation rates were high for all standard childhood immunisations when compared to local and national figures. Children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Robust safeguarding procedures were in place and all staff had received appropriate training to protect children and vulnerable adults from risk of harm.

Working age people (including those recently retired and students)

Good

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. For example appointments were available in the evening or on Saturday mornings. Appointments, prescriptions and registration were all available on line which improved access for working patients. The practice was proactive in offering a full range of health promotion and screening that reflected the needs for this age group for example travel vaccinations, family planning, and health screening.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including looked after children, vulnerable adults and children and those with a learning disability. It offered longer appointments for people with a learning disability or those who required them.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and had received additional training for this. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of normal working hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

People experiencing poor mental health had been offered an annual physical health check and psychological therapies and the local mental health service were accessible at the practice. All staff had received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and were able to explain their role in relation to this. Patients experiencing poor mental health and those with dementia had a named GP to ensure continuity of care and a single point of contact for other agencies when discussing care needs.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection we left a comment box and cards for patients to complete. We received 27 completed comment cards. Of those we received 24 had wholly positive comments, expressing views that the practice offered an excellent service with understating, caring and compassionate staff, and committed, caring GPs.

The national patient survey from January 2015 showed that 119 patients had taken part. Comments were generally positive although patients stated they had difficulty in accessing an appointment and did not always feel involved in the design and planning of their care. For example 71% of practice respondents said the GP was good at involving them in care decisions compared to a CCG figure of 84%. Additionally 64% of patients described their experience of making an appointment as good compared to a CCG average of 74%

However, data showed that 92% said the GP was good at listening to them and 95% said the last appointment they got was convenient. This compare favourably with the CCG averages of 90% and 92% respectively.

We spoke with four patients during our inspection, including members of the PPG. All patients said they were happy with the care they received, and felt the staff were all professional, approachable, and caring.

Areas for improvement

Action the service SHOULD take to improve

- Ensure patients are involved in agreeing and are able to make informed decisions about their care
- Update the lone worker policy to ensure support is available at weekends

Wellbrook Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor and a practice manager specialist advisor.

Background to Wellbrook Medical Centre

Wellbrook Medical Centre is based in the Derby Suburb of Hilton and provides primary health care to patients living in the area

The practice has a contract to provide General Medical Services (GMS) for patients.

The practice provides a number of specialist clinics and services. For example long term condition management including asthma, diabetes and high blood pressure. It also offers services for family planning, immunisations, health checks, foreign travel vaccines, minor illness and minor surgery. It also offers a phlebotomy service. Phlebotomy is the taking of blood from a vein for diagnostic tests.

A team of four GP partners, two salaried GP's, two practice nurses, a health care assistant, and 19 administrative staff provide care and treatment for approximately 10,400 patients. There are four female and two male GPs.

The practice is open between 8.00am and 6. 30pm Monday to Friday and from 8.00am to 12.15pm on Saturdays. Appointments are from 8.30am to 12:00pm every morning and 3.30pm to 6pm daily. Late night appointments are available on Thursdays between 6.30pm and 8.00pm. Patients can book appointments with the GP up to four weeks in advance and with the nurse up to six weeks in advance. The practice does not provide an out-of-hours service to their patients but patients are directed to the out-of-hour's service, Derbyshire Health United when the practice is closed.

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 (Regulated Activities) Regulations 2014 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 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 data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

Detailed findings

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)

Before carrying out our inspection, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We spoke with members of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We did this to help us to understand the care and support provided to patients by the practice.

We carried out an announced inspection on 20 May 2015 at the practice. During our inspection we spoke with the four GP partners, a nurse, a health care support worker, district nurse, community midwife and a care co-ordinator. We also spoke with, three receptionists, the practice managers and four patients. We observed how patients were cared for. We reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of significant event meetings where issues were discussed. The practice produced an annual report of significant events which was reviewed and any themes or trends identified. We saw that staff were proactive in raising significant events and that learning from them was shared with all staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of 13 significant events that had occurred during the last year and we were able to review these. Monthly significant events meetings were held to review and share learning from them. We saw that the practice had learned from these and that the findings were shared with relevant staff. For example, a significant event was raised when a batch of shingles vaccine was accidentally destroyed by being stored incorrectly. The investigation found the vaccines had been stored at the rear of the fridge and had frozen to the cooling element. Measures were put in place to prevent the issue reoccurring including further education for all staff and a modification of how vaccines were stored. We did not see evidence of any similar incidents following this. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used significant event forms to record events and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We looked at several of these significant events and saw they had been investigated in a timely manner and actions had been taken to prevent them from happening again. We saw evidence showed that all significant events were discussed at following meetings to record any additional learning or conclusion of the investigation.

National patient safety alerts were disseminated by the assistant practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We saw that all members of staff had received safeguarding training appropriate to their role, including all six GP's one of whom was the designated lead for safeguarding, who had attained level three safeguarding qualifications. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and who to speak to in the practice if they had a safeguarding concern. We saw that regular meetings were held with relevant staff to discuss any safeguarding concerns.

They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for these agencies were easily accessible.

There was a chaperone policy in place at the practice for staff to refer to for support. Signs informing patients of their right to have a chaperone present during any examination were clearly displayed throughout the practice. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing and reception staff had been trained to act as chaperones and had been checked under the Disclosure and Barring Scheme to make sure they were suitable to undertake this role. We spoke with two members of staff who clearly described to us their role and responsibilities in protecting patients from the risk of abuse and knew what action to take if they had any concerns.

Medicines management

Good

Are services safe?

Medicines at the practice were stored securely. The practice had a very robust and well organised system to ensure that refrigerated medicines were in date and stored at the correct temperature. Arrangements were in place to ensure medicines including those in GPs' bags were in date. We saw that patients' repeat prescriptions were reviewed regularly to ensure they were still appropriate and necessary.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

We saw data prepared by the local Clinical Commissioning Group (CCG) of the practice's performance for prescribing a number of medicines. This showed that the practices rates for prescribing of anti-inflammatory drugs was in line with other practices in the CCG and below the national average.

Cleanliness and infection control

The practice was visibly clean and tidy and staff followed appropriate infection control procedures to maintain this standard. The practice carried out regular infection control audits and where issues had been identified action had been taken to improve in these areas. For example, alcohol hand gel dispensers had been relocated to the most useful point in rooms and posters displaying hand cleaning techniques were displayed next to them.

Reasonable steps to protect staff and patients from the risks of health care associated infections had been taken. Staff had received relevant immunisations and support to manage the risks of health care associated infections. A legionella risk assessment had been completed in September 2013 and again in April 2014 to protect patients and staff from harm and additional training had been provided for staff on how to minimise risk. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. We saw that there were procedures in place to prevent the growth of legionella. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead for infection control who at the time of our inspection had not undertaken further training, however we saw this had been booked which would enable them to provide advice on infection control. All staff had received training about infection control specific to their role in March 2015. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment maintenance logs that demonstrated that all electrical equipment had been tested and maintained regularly. For example, all portable electrical equipment had been tested in September 2014 and medical devices were calibrated in March 2015 to ensure they were safe to use.

Staffing and recruitment

There were sufficient numbers of staff with appropriate skills to keep people safe. Staff rota systems were in place and assessments for the needs of additional staff had been carried out. These took into account changes in demand, annual leave, patient requests and sickness. For example, locum GP's were booked to work at the practice to cover planned leave, training or other absences. Records showed that appropriate checks were undertaken prior to employing staff, such as identification checks and Disclosure and Barring Service checks.

Monitoring safety and responding to risk

The practice had assessed risks to those using or working at the practice and kept these under review. However we asked the practice to update their lone worker policy to ensure support was available for staff at weekends. The practice told us they would do this. Patients with a change in their condition were reviewed appropriately. Patients with an emergency or sudden deterioration in their condition were referred to a duty GP for quick assessment.

Good

Are services safe?

Annual and monthly checks of the building had been carried out. For example, a fire risk assessment and fire drills for staff; gas safety checks and emergency lighting tests.

Arrangements to deal with emergencies and major incidents

There were emergency procedures and equipment in place to keep people safe. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff had received cardio pulmonary resuscitation training, oxygen and a defibrillator was available, which staff were trained to use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of IT, adverse weather, unplanned sickness and the loss of domestic services. The business continuity plan included important contact numbers for use in the event of the loss of one of these services.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff routinely referred to guidelines from the National Institute for Health and Care Excellence (NICE) when assessing patients' needs and treatments. There was a system in place to inform staff of any changes in the NICE guidelines they used. We saw that practice protocols based on NICE guidelines had been developed for staff to refer to. We saw that the practice had also used NICE guidelines in their analysis of significant events and in carrying out clinical audits.

Practice nurses managed specialist clinical areas such as Nurse prescribing, diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, Cardiac failure and INR monitoring. International normalized ratio (INR) is used to measure how efficiently a person's blood clots. The test is used for patients taking medicine such as Warfarin. Care was planned to meet identified needs and was reviewed through a system of regular clinical meetings.

The GPs we spoke with used national standards for the referral of patients to other services. For example, two weeks for patients with suspected cancer to be referred and seen.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and outcomes. This included data for the Quality and Outcome Framework (QOF), clinical audits, and compared its performance against other practices in the CCG. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The practice had performed higher than many other practices in several areas and had achieved 96.5% of QOF points in 2014-2015.

The practice showed us six clinical audits that had been undertaken in the last year. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, one of the GPs at the practice had reviewed the local area prescribing committee guidelines for the treatment of patients with Osteoporosis (a condition which causes bones to lose structure and become brittle). The updated guidance stated patients with osteoporosis should be prescribed a specific medicine. The second audit cycle demonstrated that the percentage of patients receiving this medicine had risen from 70% to 82.5%. Other examples included audits of joint injections, minor surgery, referral rates to a number of different services and A&E attendances.

The practice reviewed patients attending the INR clinic and identified a concern regarding the level of information patients were provided with when they were initially started on warfarin. As a result of this they raised their concerns as a significant event and arranged a meeting with the head of clinical quality and patient safety at the CCG. As a result of this further meetings were held between CCG and hospital staff which resulted in improved information for patients and safer discharge from hospital care.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The electronic system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice was working towards the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Staff had received training appropriate to their roles, and had protected learning time for on going training. They were supported in attending external courses where required. Continuing professional development for nurses was monitored through appraisals, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice. There was a good skill mix among the GPs with Pathology, obstetrics, child health and family

planning amongst the additional qualifications GPs had attained. All the GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Checks were made on qualifications and professional registrations as part of the recruitment process. Staff were given an induction and further role specific training when they started. Staff we spoke with told us they could access additional training when required and felt supported in their role. For example one nurse told us the practice had funded a 'Near Patient Testing' course which meant they could run the INR testing clinic which improved access to services for patients.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. We spoke with a district nurse, community matron and a care coordinator during our inspection. They told us the practice worked with them to meet the needs of patients and that there were effective communication pathways in place to support the sharing of information. They told us that this practice compared favourably with similar services in the area for communication with and involvement of external staff. Regular meetings were held to discuss the needs and treatment strategies of patients with long term conditions; palliative care needs and vulnerable and older frail patients who were at high risk of unplanned hospital admissions. These were attended by other professionals including district and palliative care nurses.

Feedback form care home staff showed that they valued the service they received from the practice, particularly highlighting the single doctor service which ensured effective communication and continuity for patients.

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and responsibilities.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local GP out-of-hours provider that enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals to other services

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All the staff were fully trained on the system.

Consent to care and treatment

All the clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Staff were also aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff had received recent training in the mental capacity act.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed a minimum of annually.

Health promotion and prevention

The practice offered new patient health checks, and NHS checks for patients aged 40-75. Advice was available on stopping smoking, alcohol consumption and weight management. Patients over the age of 75 were allocated a named GP. The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data

Good

Are services effective?

(for example, treatment is effective)

collected by NHS England for 2013 -2104 showed that performance for all childhood immunisations was at or above the average for the CCG for all age groups. Practice nurses used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition. The practice website contained health advice and information on long term conditions, with links to support organisations.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice data clerk carried out a regular audit of patients attending the INR clinic. The international normalised ratio (INR) is a laboratory measurement of how long it takes blood to form a clot. It is used to ensure patients receiving anti coagulation medicines such as warfarin are receiving the correct dose of the medicine. If any patient had not been seen in the preceding eight weeks the practice nurse was informed and the patient contacted. Similarly if a patient cancelled their appointment at the clinic without booking a follow up, the administrative team would contact them to arrange a new one. Additionally the data clerk created a report to identify patients with high blood pressure. If these patients had not been seen in clinic in the past six months an appointment was made for them to attend for review. This helped to ensure patients who required additional support were not missed.

The practice's performance for cervical smear uptake was 84.6% which was above the CCG figure of 77.7%. The practice also performed well on screening for breast (84.8%) and bowel (67%) cancers when compared to the CCG figures of 78.5% and 61% respectively.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 4 patients during the inspection, and collected 27 Care Quality Commission (CQC) comment cards. Comments were mainly positive. Patients told us the staff were always helpful, professional, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. They said that the receptionists were helpful.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015 and a survey of 333 patients undertaken by the practice in February 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data showed that 95% of respondents said that their last appointment was convenient; which was higher than the Clinical Commissioning Group (CCG) average of 90%. Additionally 93% of respondents said the last nurse they spoke with was good at listening to them. The practice was above the CCG regional average for its satisfaction scores on consultations with GPs and nurses. For example, 92% of respondents said the GP, and 93% said the nurse was good at listening to them. This was above the CCG regional average of 90% and 91% respectively.

Consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk, which prevented patients overhearing potentially private conversations between patients and the reception staff. We observed a number of telephone calls to the switchboard and noted that staff were polite and courteous and ensured they confirmed the callers' identity before sharing any sensitive information.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey showed that not all patients who responded were satisfied with their level of involvement in planning and making decisions about their care and treatment. They rated the practice below CCG average in these areas. For example, data from the survey showed 71% of practice respondents said the GP was good at involving them in care decisions and 80% felt the GP was good at explaining treatment and results. Both these results were below the CCG averages of 84% and 88% respectively. However the four patients we spoke with on the day of our inspection told us that 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 enough time during consultations to make an informed decision about any treatment suggested. Patient feedback on the comment cards we received was also positive regarding involvement and communication.

We saw that 87% of patients responding to the GP patient survey said the last nurse they saw or spoke to was good at involving them in decisions about their care. This was the same as the CCG average of 87%.

Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 93% of respondents to the national patient survey said the last nurse they saw or spoke with was good at treating them with care and concern. This was above the regional average of 91%. The patients we spoke with on the day of our inspection and the comment cards we received were also

Good

Are services caring?

consistent with this survey information. The practice kept registers of patients who needed extra support, such as those receiving palliative care and their carers, and patient experiencing poor mental health.

Notices in the patient waiting room, patient website informed patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice recognised the importance of maintaining a carer's health to enable them to continue to provide care and support to the people they provided cared for.

The practice had a system in place to support patients known to them who had suffered a recent bereavement. The practice sent out bereavement cards to relatives and a GP telephoned them to check on their health and welfare.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs and future needs of the practice population were clearly understood and systems were in place to address identified needs in the way services were delivered. For example, a local care home provided specialist care for patients with Huntington's Disease (an inherited condition that damages certain nerve cells in the brain). To ensure patients had access to the best possible care, the practice had instigated joint visits to the care homes with a Professor from the Department of Rehabilitation at Royal Derby Hospital, who has a special interest in Huntington's Disease, and the regional adviser from the Huntington's Disease Association. GPs told us these visits had enhanced the care received by these patients and also had increased their own knowledge and effectiveness in their treatment.

Clinics aimed at teenagers and young people, for example for vaccination and immunisation, were held outside school hours to ensure patients were able to access the service.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, the PPG had carried out a survey of patients experiences of making an appointment. This identified that patients were not aware of all the options available to them to access the service, for example evening and Saturday clinics. The PPG told us they planned to work with the practice to better promote the appointment options available.

Tackling inequity and promoting equality

The practice had provided equality and diversity training for all the staff. The practice recognised the needs of different groups in the planning of its services. For example telephone and text reminders for appointments were sent to patients to ensure they did not forget them.

The practice was in a purpose built two storey building with services for patients provided on the ground floor. The waiting rooms were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Facilities for patients with mobility difficulties included six disabled parking spaces; four parent and child parking spaces; step free access to the front door of the practice; electronic entrance doors; disabled toilets and a hearing loop for patients with a hearing impairment were available.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday, with extended hours to 8.00pm on Thursdays. The practice was open on Saturdays from 8.30am to 12.15pm for pre booked appointments only. Appointments were available from 8.30am to 12:00 pm and from 3.30pm to 6.00pm daily with extended appointments 6.30pm and 8.00pm on Thursday. The practice did not routinely provide an out-of-hours service to their own patients but patients were directed to the out of hours service Derbyshire Health United (DHU), when the practice was closed.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments either online or by telephoning the practice. Patients were also able to request prescriptions via the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients told us they were dissatisfied with the appointment system at the practice, stating they could not always get an appointment at a convenient time or with the GP of their choice. This was supported by the national patient survey carried out during January-March 2014 and July-September 2014. This showed that 66% of respondents found it easy to get through on the phone compared with the local Clinical Commissioning Group average of 75% and a national average of 73%. Sixty four

Good

Are services responsive to people's needs?

(for example, to feedback?)

per cent of respondents described their experience of making an appointment as good or very good which was below the CCG average of 74% and a national average of 73%. However survey results showed that 95% of patients felt their last appointment was convenient, this figure was 92% for both the CCG and nationally. Sixty five per cent felt they didn't have to wait too long for their appointment. This compared favourably with the CCG (62%) and national (58%) figures. The practice had taken measures to address access concerns, for example increased use of locum GP's and providing telephone appointments. There was some evidence that these steps were having a positive effect, for example, the number of complaints received by the practice regarding access had decreased compared to the previous year.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated person who handled all complaints in the practice. Information on how to complain was in the patient information leaflet and on the practice's website.

We saw notes of a meeting to review all complaints received over the previous 12 months. This showed that 36 formal complaints had been made during the last 12 months, either verbally or by letter and all had been responded to in line with the practice's complaints policy. The practice had identified any trends in complaints and compared these to the trend for previous years. We saw that learning from complaints was discussed and shared with all staff. For example staff offered reminders to patients to check their prescriptions before submitting them to the pharmacy, to ensure they matched what they were expecting.

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 which was communicated with all staff.

- To provide the highest standards of health care to our patients, within the resources available.
- To provide a team approach to patient care and endeavour to monitor the service provided to patients, to ensure that it meets the current standards of excellence.
- To be dedicated to ensuring that the practice staff and Doctors are trained to the highest level and to provide a stimulating and rewarding environment in which to work.

This was clearly displayed throughout the practice for staff and patients to see. All the staff we spoke with were clear about the vision and their responsibilities in relation to this.

Governance arrangements

There was a very clear leadership structure within the practice. Staff were clear about their roles and responsibilities and felt supported by the management in these. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor quality and identify risk. Data from the Quality and Outcomes Framework (QOF) showed the practice was performing at or above national standards. The practice regularly reviewed its results and how to improve.

The practice was proactive in responding to risk and ensuring a continuous high quality service was offered. For example we were shown a planning document designed to ensure GP cover was available when one of the partners left the practice.

The practice had identified lead roles for areas of clinical interest or management. A programme of clinical audits was in place. Five of the six audits we were shown included follow up audits that demonstrated suggested changes to practice had improved health outcomes for patients. From our discussions with staff we found that they were committed to the continual improvement of the service and had access to support, additional training and resources to help them do this.

Leadership, openness and transparency

Staff we spoke with were positive about working at the practice. They told us they felt supported to deliver safe, effective and responsive care. Staff described the culture at the practice as open and transparent. They told us they felt comfortable to raise any concerns when required and were confident these would be dealt with appropriately. The GP partner's valued partnership working and recognised the strength of having a strong, cohesive staff team.

Regular whole practice, clinical and team meetings were held and staff felt confident to raise any issues or concerns at these meetings. A daily protected 'coffee break' was held after morning surgery for clinical and management staff to discuss any concerns or developments. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, public and staff

There was an active patient participation group (PPG) at the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Regular patient surveys and action plans were carried out and published on the practice's website for the practice population to read. For example looking at access to appointments. We saw that PPG members were actively involved with the practice and provided practical assistance when required. For example members helped with running and promoting recent flu clinics, including directing patients where to park.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns with colleagues and management and that they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff told us they were able to ask for additional training for their role.

Management lead through learning and improvement

Are services well-led?

Good

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

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Annual appraisals had been carried out and staff had identified learning objectives and training needs.

The practice was an undergraduate training practice which supported medical students. The practice was a member of the Primary Care Research Network (PRCN) and had participated in five research projects during 2014/15. The practice had completed reviews of significant events and other incidents, and shared these with staff at significant event meetings and team meetings.