Clay Cross Medical Centre

Inspection report

Bridge Street
Clay Cross
Chesterfield
Derbyshire
S45 9NG
Tel: 01246862237
www.ClayCrossSurgery.co.uk

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

Ratings

Overall rating for this location	Good
Are services safe?	**Good**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This practice is rated as Good overall. (Previous rating 09 2017 – Requires improvement).

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Clay Cross Medical Centre on 3 July 2018. At the previous Care Quality Commission (CQC) inspection in July 2017, the practice received an overall requires improvement rating. The practice was deemed to require improvement for providing effective and well-led services, but was rated as good for providing safe, caring and responsive services. The full comprehensive report on the July 2017 inspection can be found by selecting the 'all reports' link for Clay Cross Medical Centre at . This inspection was undertaken to ensure that improvements that had been made following our inspection in July 2017.

At this inspection we found:

- We found that there had been some significant improvements within the practice. The appointment of a new practice manager and a restructuring of the management team was helping to drive improvements.
- Building on the action plan developed from previous inspections, a wider practice development plan was in place to plan for the future.
- Following some personnel changes within the practice team over the previous year, there had been difficulties in providing continuity, particularly in respect of nursing. This had stabilised by the time of our inspection, giving a stronger foundation for further development.
- We observed that staff turnover had impacted significantly on the practice's performance in the 2017-18 achievement for the Quality and Outcomes Framework (QOF), which had decreased by approximately 20%. This also impacted on a relatively low number of patients with a learning disability having an annual review of their needs. However, a plan had been produced to rectify this, and we observed that improvements were being made.
- The practice ensured that care and treatment was delivered according to evidence-based guidelines.
- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The partners acknowledged that more GP capacity was required and continued to try and address this. However, skill mix arrangements with advanced nurse practitioners and a part-time pharmacist provided more options for patients to see the right professional to meet their own needs.
- Appointment systems had been recently revised and we observed that this was facilitating easier access to care when it was needed. The procurement of a new and improved telephone system was nearing completion which would impact positively on patient experience.
- There was a stronger focus on listening to patients and responding to their feedback. An action plan had been developed in response to a recent internal patient survey, and we saw how this aimed to respond positively to what patients had said.
- The practice encouraged learning and improvement, and we saw that staff were up to date with the practice's training schedule.
- The Clinical Commissioning Group's (CCG) medicines management team told us that the practice engaged well with them. However, there was scope for further improvement in reducing the prescribing of broad-spectrum antibiotics, and cost-effective prescribing in line with guidance.
- The practice had established good working relationships with other local GP practices and the GP federation, and this collaborative work was producing good outcomes in improving services for patients and the practice team.

The areas where the provider **should** make improvements are:

- Improve quality of care and patient outcomes as part of annual QOF performance.
- Continue to review the prescribing of broad-spectrum antibiotics.
- Ensure an effective immunisation programme is in place to include records to confirm the immunisation status of staff who have direct contact with patients.

Overall summary

- Take action to ensure higher rates of patients with a learning disability are seen for an annual review of their needs.
- Continue to identify patients who are carers and ensure they receive appropriate advice and support.
- Develop more comprehensive evidence of discussion at clinical and management meetings to reflect discussions of topics such as complaints, significant events and new guidance.

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

Please refer to the detailed report and the evidence tables for further information

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist advisor, and a nurse specialist advisor.

Background to Clay Cross Medical Centre

Clay Cross Medical Centre is registered with the CQC as a partnership of two GPs.

The practice is situated in the Clay Cross area of North-East Derbyshire. It provides primary care medical services commissioned by NHS England and NHS Hardwick CCG. It operates over two sites:

- Clay Cross Medical Centre, Bridge Street, Clay Cross, Chesterfield, Derbyshire. S45 9NG
- Tupton Surgery, Queen Victoria Road, Tupton, Chesterfield, Derbyshire. S42 6ED (branch site).

The practice has one patient list, meaning that registered patients can access services at either of the two sites. We visited the main site as part of our inspection.

The practice has a population of approximately 6,150 registered patients. There has been a slight reduction in patient numbers since our previous inspection. Patients are predominantly of white British origin with 2.1% of patients being from BME groups. The age profile of registered patients shows a higher percentage of older patients in comparison to national averages, with 25% of their patients aged 65 and over, in comparison to a national average of 17%. The practice serves a population that is ranked in the fifth more deprived decile for deprivation. Clay Cross is a former mining area which has contributed to a slightly higher prevalence of long-term conditions by comparison to the national average.

There are 24 staff working at the practice. The clinical team consists of two GP partners (one male and one female). A part-time male GP had recently commenced working at the practice as part of the GP retention scheme. Regular locum GPs also provide input at the practice at the time of our inspection. There are two advanced nurse practitioners and three practice nurses, a part-time pharmacist, and a healthcare assistant. The clinical team is supported by a practice manager and assistant practice manager (who is also the practice's care coordinator), a practice business administration coordinator, and a team of 12 reception, secretarial and administrative staff.

Clay Cross Medical Centre is not a training or teaching practice for medical students or post graduates.

The main site opens from 8am until 6.30pm Monday to Friday, with extended opening hours until 8pm on one day each week. Scheduled GP appointment times are available each morning between 8.30am to 12pm and on each afternoon from 3pm to 6pm. Appointments are available during the extended opening hours until 7.45pm. The branch site opens at different times.

The surgery closes for one Wednesday afternoon each month for staff training. When the practice is closed, patients are directed to Derbyshire Health United (DHU) out of hours via the 111 service.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. Staff who acted as chaperones were trained for their role and 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).
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens mostly kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- The practice was not able to provide records of the appropriate vaccination status for all clinical staff, although staff who did not have the supporting documentation told us they had received the necessary protection. The practice told us they would ensure that tests would be repeated where test results were absent, and the oversight of this would be strengthened. They supported this with a new policy provided after the inspection.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and had taken some action to support good antimicrobial stewardship in line with local and national guidance. However, we saw that further work was required on this and this was being reviewed in conjunction with the CCG's medicines management team.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were a range of risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Good

Are services safe?

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Partners and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Requires improvement

Are services effective?

We rated the practice and all of the population groups as requires improvement for providing effective services overall.

Effective needs assessment, care and treatment

Clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Templates on the practice computer system linked with guidance to ensure care was provided in accordance with current evidence-based practice. Any new or revised guidance was discussed at regular clinical meetings, although minutes of the meetings observed did not always clearly reflect this.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of their prescribed medications.
- The practice team worked effectively with community based health and care staff including the community matron as part of an integrated approach to care. Weekly multi-disciplinary 'virtual ward' meetings reviewed the ongoing care and support for patients who were at risk of hospital admission or had complex health and care needs. A member of the practice team worked some hours as a care coordinator to ensure the changing needs of these patients was kept under review and met.
- The practice followed up on older patients who had received treatment in hospital or through out of hours services. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Specialist advice was accessed via a locality geriatrician service (a geriatrician is a medical doctor who specialises in the diagnosis, treatment, and prevention of disease and disability in older adults). The geriatrician would provide advice and undertake home visits when required, and this helped to reduce the number of hospital admissions.

People with long-term conditions:

- Data provided by the practice for 2017-18 showed a significant reduction in their QOF achievement, meaning that outcomes for patients were lower than local and national averages. However, we did see that levels of exception reporting continued to decrease.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.
- For patients with the most complex needs, the practice team worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- There was an emphasis on patient empowerment and support for individuals in the management of their long-term condition.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90% or above. Most of these indicators exceeded the World Health Organisation's target of 95% uptake.
- The practice had arrangements for following up failed attendance of children's appointments in secondary care or for immunisation.
- Monthly safeguarding meetings were held to ensure any children at potential risk of harm were kept under review and received the appropriate support from the practice and the wider health care team. In addition, an annual safeguarding meeting was held with the area lead GP for safeguarding.
- The practice worked with midwives, health visitors and school nurses to support families.

Requires improvement

Are services effective?

- Expert advice was available from a paediatric consultant and referrals could be made to a rapid access clinic to enable children to be seen within the consultant-led service on the same day.

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

- The practice's uptake for cervical screening was 73.2%, which was below the 80% coverage target for the national screening programme. Non-attenders had a flag marker added to their screen so that this could be discussed and encouraged when the patient attended for a consultation.
- The practice's uptake for breast and bowel cancer screening was above or in line with the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Care plans were developed and agreed with patients.
- The practice offered annual health checks to patients with a learning disability. The practice told us that 14 patients (52% of those patients on their learning disability register) had received an annual review of their health needs during 207-18. The practice acknowledged this needed improvement and the shortfall had arisen due to service continuity problems caused when previously employed nursing staff had left.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, and access to 'stop smoking' services.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. A newly appointed GP had completed additional training on dealing with the risk of suicide.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice's performance on quality indicators for mental health was below local and national averages. Performance had declined from 2016-17 with an overall mental health QOF achievement of 93% to 67% in 2017-18 (based on practice data awaiting verification).

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- The practice's performance on quality indicators for long term conditions was in line with local and national averages for the period 2016-17. However, the practice provided us with data for their Quality and Outcomes Framework (QOF) submission for 2017-18, which showed a significant decrease in achievement from 98.4% to 78.7%. This data remains subject to external validation. The practice explained that this decline had occurred as a consequence of the upheaval in the nursing establishment over the last 12 months. They were able to demonstrate that a clear plan was in place to address this and systems had been reviewed to facilitate improved outcomes for patients. This included a proactive approach based on individual assessment of each patient's records and healthcare needs, along with reporting from data in the clinical system. Improvements in data recording and data quality at the practice had supported this process significantly.
- The practice had taken action to address a higher rate of clinical exception reporting in QOF. This was 16% in 2015-16, and this had been reduced to 11.4% for 2016-17. The practice provided us with their own data (subject to external verification) which demonstrated a

further improvement to 7.3%, although this was in the context of a lower overall achievement. The practice had made efforts to engage with patients to reduce exception reporting, for example by telephoning patients to stress the importance of attending a review to monitor their condition.
- The practice used information about care and treatment to make improvements.
- The practice was involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Records of skills, qualifications and training were maintained and were observed to be up-to-date. Staff were encouraged and given opportunities to develop. For example, the health care assistant had originally been appointed as a receptionist. They had been supported to undertake training including completion of the Care Certificate, alongside internal mentoring and access to advice.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included appraisals, mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans where appropriate.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances. This included sharing appropriate information with the out of hours provider for example, to ensure the patient received the right care promptly in line with their preferences.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, a campaign to raise awareness on pre-diabetes was recently promoted.

Consent to care and treatment

Requires improvement

Are services effective?

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, and social needs.
- The practice gave patients timely support and information.
- The national GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice identified carers and supported them.
- The practices GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this. This was supported by a practice dignity and respect policy.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations with a GP or advanced nurse practitioner were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- Individuals aged 65 and over accounted for 25% of the registered patients at the practice. The practice team took account of this when planning any service developments or changes.
- The practice was responsive to the needs of older patients, and offered longer or urgent appointments for those with enhanced needs. The GP and nurses also accommodated home visits for those who had difficulties getting to the practice.
- The practice provided primary care services to a local residential home for 21 clients and to a small number of patients who lived in other local homes. The practice saw these patients when requested, but did not have a regular scheduled visit.
- Access to social prescribing schemes through the voluntary single point of access, facilitated non-clinical support services to keep patients well in their own homes.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local community health and social care teams to discuss and manage the needs of patients with complex medical issues.
- Appropriate patients were directed for support to the well-being worker and services such as the Citizens Advice Bureau.
- Newly diagnosed patients with diabetes were referred into a structed education programme to help them manage their condition.
- GPs utilised a consultant advice service through their local acute hospital to access expert advice in a timely manner to support patient care.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. Children under five were always prioritised.
- The reception area was suitable for children with an activity play table. Children were encouraged to draw pictures for the surgery to help reduce their anxieties.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were provided on one evening a week, and telephone consultations were also available.
- Online services were available to patients including booking and cancelling appointments; ordering repeat prescriptions and having any medicines sent to their pharmacy of choice for collection; and access to view part of their own clinical record.

People whose circumstances make them vulnerable:

Good

Are services responsive to people's needs?

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice held a range of resources (such as easy-read letters) to help communicate with patients with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Monthly palliative care meetings were held to review those patients approaching end of life.

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

- Staff had a good understanding of how to support patients with mental health needs and those patients living with dementia. For example, extra support was provided whilst patients waited to secure specialist help, and anxiety management was offered to patients with dementia and their carer.
- The practice worked closely with the community mental health patients to support patients.
- A counsellor held clinical sessions on site to support people experiencing stressful and emotional difficulties.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- The practice had introduced a revised system for appointment bookings from June 2018. More online booking was made available for patients, and new appointments were opened each day from 8am for patients ringing or attending the practice. Once capacity had been reached, a triage system came into operation which was reviewed by both the GPs and advanced nurse practitioners. Any urgent cases were identified on a separate list and would be contacted as soon as possible during the surgery, whilst others were telephoned if clinicians had a space in their list, or at the end of their booked session. Staff told us that this system was much better for them and also offered greater access to patients. An analysis of the first month had shown that whilst the demand for triage was initially high, it had settled down to manageable numbers. The practice told us that they hoped the new procedure would reduce DNA (did not attend) appointments by up to 40 per month, and figures for the first month reflected this.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients mostly reported that the appointment system was easy to use.
- The national GP patient survey results were in line with local and national averages for questions relating to access to care and treatment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- GP partners and managers were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Managers were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had processes to develop leadership capacity and skills.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a mission statement and set of values. Managers articulated a realistic strategy and whilst there was no formal business plan, a practice development plan set priorities.
- Staff were aware of and understood the values and the content of the practice development plan and their contribution to this.
- The strategic direction was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.

Culture

The practice had a culture of high-quality sustainable care.

- The practice focused on the needs of patients. The practice told us that their aspiration was to make every contact count.
- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing staff with the development they need, including appraisal and career development opportunities. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally. There was a practice cultural and religious policy for staff and patients.
- There were positive relationships between staff and teams. New staff had been welcomed into the team and integrated quickly with their colleagues.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There was a schedule of regular in-house meetings including a weekly clinical and management meeting. Minutes were available although we observed some recent copies which showed limited reference to the discussions held.

Managing risks, issues and performance

There were clear processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leads had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had developed a business continuity plan in order to respond to any major incidents.

Good

Are services well-led?

- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings.
- The information used to monitor performance and the delivery of quality care was reviewed with plans to action any identified weaknesses. Regular engagement with the CCG helped to discuss any outlying areas of performance and address these.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice responded positively to suggestions from staff to improve services. For example, set clinics had been removed and any patient could be booked in to see the practice nurse or health care assistant. This provided more choice and better access for patients. Also, when it was identified that emergency equipment was not easy to manoeuvre, grab bags were provided to make this easier.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- The practice had successfully bid for resilience funding working in collaboration with three other local practices and the GP federation to assist ongoing developments. For example, a receptionist development programme to upskill staff, and the alignment of policies and training to enable future joint working.
- The practice was also working with the federation and four small local practices on projects including extended access, a centralised approach to information governance via an outsourced supplier, the management of patient DNAs, and a cancer significant event audit.
- The practice had recently introduced an allocated administrator to work with each GP for each clinical session. This ensured continuity and avoided interruptions from other members of the team. The allocated worker would undertake any appropriate tasks and collate any mail or other information for the GP to review during that session. This had impacted on the GPs in terms of allowing them to focus on patient care during their clinical session.
- Clay Cross Medical Centre was one of two local practices involved in a CCG led prescriptions 'Medicines Order Line' (MOL) as a pilot site allowing patients across Derbyshire to order repeat prescriptions by telephone. The intention was that this would then be rolled out more widely.
- The practice planned to introduce a weekly 'huddle' meeting in the near future to facilitate team discussions on any presenting issues in a more informal environment.
- The practice made use of incidents and complaints. Learning was shared and used to make improvements.
- GP partners and managers encouraged staff to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.