Dr DJ Collins' Practice

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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr DJ Collins (The Springs Health Centre) on 28 September 2016. Overall, the practice is rated as good.

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

- There was an effective system in place for the reporting and recording of significant events. Learning was applied from events to enhance the delivery of safe care to patients.
- Clinicians kept themselves updated on new and revised guidance and discussed this at clinical meetings. Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- We saw evidence of an active programme of clinical audit that reviewed care and ensured actions were implemented to enhance outcomes for patients.
- Patients told us they were treated with compassion, dignity and respect. They also said they were involved in their care and decisions about their treatment. This was corroborated bythe outcomes of the latest national GP patient survey and CQC comment cards.
- The practice planned and co-ordinated patient care with the wider health and social care multi-disciplinary team to deliver effective and responsive care to keep vulnerable patients safe. Fortnightly meetings took place to discuss and review patients' needs.
- The practice directly employed two community matrons and a part-time care co-ordinator to deliver and co-ordinate care and support to vulnerable patients in their own homes.
- The practice had an appraisal system in place and supported staff training and development. The practice team had the skills, knowledge and experience to deliver high quality care and treatment.
- Arrangements were in place to assess and manage risk effectively.
- Feedback from patients we spoke with on the day, and from CQC comment cards, demonstrated that people had good access to GP appointments.
- The practice had good facilities and was well-equipped to treat patients and meet their needs. The premises were accessible for patients with impaired mobility.

Summary of findings

- The practice provided care to residents across three local care homes for older people. Regular planned visits to the home by both the community matron and by a GP ensured continuity of care and a reduction in the number of acute visits.
- There was a clear leadership structure in place and the practice had a governance framework which supported the delivery of good quality care. Regular practice meetings occurred, and staff said that GPs and managers were approachable and always had time to talk with them.
- The practice management team consisted of the GP partners, the practice manager and the nurse manager. All decisions were agreed collectively as a team rather than solely as a partnership, demonstrating a more inclusive approach to decision making within the practice.
- The partnership had a vision for the future. They were proactively engaged with their Clinical Commissioning Group (CCG) in order to provide joined-up care closer to people's homes via an integrated care model.
- The practice had an open and transparent approach when dealing with complaints. Information about how to complain was available, and improvements were made to the quality of care as a result of any complaints received.
- The practice had a patient participation group (PPG) which met bi-monthly. The practice consulted with their PPG, although we did not see evidence of the PPG driving change within the practice.

We saw the following areas of outstanding practice:

- Two community matrons worked a total of 47 hours per week. The practice directly funded half of these hours. The two matrons proactively engaged with the wider multi-disciplinary teams to deliver responsive care to support patients and their families, and provided bereavement support following a patient death. One of the matrons had worked with the CCG's lead medicines management technician on a deprescribing project (deprescribingrefers to reducing or stopping the prescribing of medicines that may be causing harm, may no longer be providing benefit, or may be considered inappropriate). The outcome of the project resulted in cost savings of almost £14,000 with 18% of prescribed medicines being stopped. Other medicines were reduced, changed or new medicines initiated after the review.
- The practice had significantly higher rates of screening for cervical and breast cancer in relation to local and national averages. For example, uptake for the breast screening programme for 50-70 year olds within six months of invitation was 84.3%, which was above the CCG average of 79.6% and the national average of 73.2%. The practice also had higher bowel screening rates than the national average and had achieved good performance in the uptake of NHS health checks. This was due to a proactive approach taken by the practice team including opportunistic reminders to patients, and motivating patients to receive screening if it was observed that they had refused the test.

The areas where the provider should make improvement are:

- Improve the uptake of annual health checks for patients with a learning disability.
- Review immunisation training updates for nurses in line with recognised standards.
- Consider a review of infection control management within the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Staff were supported to report significant events in a supportive environment. Learning was applied from incidents to improve safety in the practice.
- The practice had effective systems in place to ensure they safeguarded vulnerable children and adults from abuse.
- The practice worked to written recruitment procedures to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- Systems were mostly in place to manage medicines on site appropriately, although the system for monitoring the distribution of prescriptions within the practice required strengthening. The practice also needed to ensure that their written procedures were reflected in every day practice.
- Patients on high-risk medicines were monitored on a regular basis.
- Actions were taken to review any medicines alerts received by the practice, to ensure patients were kept safe.
- The practice had systems in place to deal with medical emergencies within the surgery.
- Risks to patients and the public were generally well-managed. The oversight of infection control management required strengthening, supported by evidence of up to date training undertaken by the designated lead.
- The practice had developed contingency planning arrangements supported by a written plan that was regularly updated.

Are services effective?

Good

- The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Regular clinical meetings took place to discuss issues such as new guidance. Clinical education sessions provided an environment of learning within the practice.
- The practice had achieved 96% of the available points in respect of the Quality and Outcomes Framework (QOF) 2014-15. This was marginally below the CCG average of 98.1%, and above the national average of 94.7%.

Summary of findings

- The practice kept their staffing skill mix under review to meet the demands of patients and to provide good access to the care that patients needed.
- The practice worked collaboratively with the wider health and social community to plan and co-ordinate care to meet their patients' needs at regular multi-disciplinary team meetings.
- Staff had the skills and experience to deliver effective care and treatment. New employees received inductions, and all members of the practice team had received an appraisal in the last year, which included a review of their training needs.
- We saw examples of how clinical audit was being used to improve quality and enhance safe patient care and treatment.

Are services caring?

Good

- We observed a patient-centred culture and approach within the practice. Staff treated patients respectfully and with kindness.
- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated that they felt treated with compassion and dignity, and were given sufficient time during consultations. Patients said they were involved in decisions about their care and treatment.
- Feedback received from community-based staff who worked with the practice was very positive about the high standards of care provided by the practice team.
- The practice team knew their patients well due to the practice being long-established with a low turnover of staff. This aided them in providing personalised care and ensured greater continuity for patients.
- We were provided with examples of individual patient stories which reflected the caring approach of the practice team.

Are services responsive to people's needs?

Good

- Comment cards and patients we spoke with during the inspection provided mainly positive experiences regarding obtaining an appointment with a GP. The latest GP survey showed that patient satisfaction was above, or in line with, local and national averages regarding access to GP appointments.
- Patients could book appointments and order repeat prescriptions on line. The practice participated in the electronic prescription scheme, so that patients could collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.

Summary of findings

- The practice hosted some services on site including counselling, and twice weekly ante-natal and post-natal clinic provided by the midwife. This made it easier for their patients to access services locally.
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The premises were tidy and clean and well-equipped to treat patients and meet their needs. The practice accommodated the needs of patients with a disability, including access to the building through automatic doors.
- The practice reviewed any complaints they received and dealt with these in a sensitive and timely manner. Information about how to make a complaint was available for patients. Learning from complaints was used to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they could be moved into a private room to ensure their privacy.

Are services well-led?

Outstanding 

- The partners were committed to the delivery of high quality care and promoting good outcomes for their patients.
- The practice management team consisted of the GP partners, the practice manager and the nurse manager. The team made decisions collectively rather than solely as a partnership, demonstrating a more inclusive managerial approach within the practice.
- GPs and nurses had lead roles providing expert advice to patients and acting as a resource for their colleagues.
- The practice had developed a range of policies and procedures to govern activity.
- The partners worked collaboratively with other GP practices in their locality, and with their CCG. This approach was supportive of the local CCG strategy for 21st century model of care to deliver treatment and support closer to patients' homes. For example, they developed collaborative models of integrated working with community-based teams to optimise the care of patients.
- The practice was innovative in being a pilot site for new initiatives. They were early adopters of new schemes, which helped place them at the forefront of developments within primary care. This included early investment in community matron posts and a practice based care co-ordinator to support vulnerable patients, as an early adopter of the care planning process

Summary of findings

- The partners reviewed comparative data provided by their CCG (such as referral rates) and ensured actions were implemented to address any areas of outlying performance.
- Staff felt well supported and valued by the management team. The practice held regular staff meetings to ensure good communication.
- The practice had sought feedback from patients, and acted on this to improve service delivery. There was a Patient Participation Group (PPG) which met every two months.

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 offered proactive and personalised care to meet the needs of older people. Care plans were in place for older people with complex needs, and the practice worked collaboratively with other providers to deliver tailored care packages to patients. Fortnightly multi-disciplinary meetings were held to review frail patients and those at risk of hospital admission to plan and deliver care appropriate to their needs.
- The practice directly employed two community matrons and their own care co-ordinator to facilitate the planning of care for patients being discharged from hospital, or to provide support to help vulnerable patients remain in their own home. Specific groups had been targeted for assessment and appropriate follow-up support including patients aged over 80, and older patients prescribed multiple medicines.
- The community matron had worked with the CCG's lead medicines management technician on a deprescribing project focussing on older patients. The outcome of the project resulted in 18% of prescribed medicines being stopped, as they were no longer needed. Other medicines were reduced, changed or new medicines initiated after the review. This impacted on care for older patients due to the potentially adverse effects associated with taking multiple medicines, such as the increased risk of falls.
- The practice provided care to residents across three local care homes for older people. Regular planned visits to the home by both the community matron and by a GP ensured continuity of care and a reduction in the number of acute visits. We spoke with managers of the homes who were very satisfied with the care provided by the practice, and described the relationship with the practice as being extremely positive and responsive to their residents' needs.
- Longer appointment times could be arranged for patients with complex care needs. Home visits were provided for those unable to attend the surgery.
- Uptake of the flu vaccination for patients aged over 65 was 71%, which was in line with local (73.9%) and national (70.5%) averages.
- The practice had actively participated with commissioners in the re-structuring of care programmes for older people to deliver joined-up services closer to patients' homes.

Summary of findings

People with long term conditions

Good

- The practice undertook annual reviews for patients on their long-term conditions registers, including a review of their prescribed medicines. Practice data showed that 87.3% of patients with chronic obstructive airways disease and 79% of patients with asthma had attended for an annual review during 2014-15.
- QOF achievements for clinical indicators were generally in line with CCG averages, and above national averages, although outcomes for diabetes were slightly lower. The practice achieved 84.3% for diabetes related indicators, in comparison to local and national averages of 96.7% and 89.2% respectively in 2014-15.
- Patients with multiple conditions were usually reviewed in one appointment to avoid them having to make several visits to the practice.
- The recall system was co-ordinated by the administration team. A protocol was in place to ensure that patients received one of 16 specific letters for their condition(s). This meant that each patient was booked into see the right person for the correct amount of time. It also accounted for follow up tests, for example after a patient had received spirometry (a test to assess breathing) or a blood test.
- There was a lead designated GP or nurse for the clinical domains within QOF.

Families, children and young people

Good

- The midwife held ante-natal clinics and saw new mothers for a post-natal review at the practice each week. The health visitor held fortnightly well-baby clinics in the practice.
- Childhood immunisation rates were high and were either in line with, or marginally above, local averages. Overall rates for the vaccinations schedule given to children up to five years of age ranged from 94.7% to 100% (local averages 95.2% to 99.1%).
- Same day appointments were provided for babies or children who were unwell.
- The practice had an identified lead GP for child safeguarding. The health visitor and midwife attended a meeting approximately every four to six weeks with the lead GP to review and discuss any child safeguarding concerns. Child protection alerts were used on the clinical system to ensure clinicians were able to actively monitor any concerns.

Summary of findings

- A full range of family planning services were accessible throughout the week. The practice had pioneered a system with the local school so that the person could present different coloured cards denoting either a request for emergency or routine contraception, without having to discuss this.
- The practice had baby changing facilities, and a small play area was available for children. The practice welcomed mothers who wished to breastfeed on site, and offered a private room to facilitate this if requested.

Working age people (including those recently retired and students)

Good

- Extended hours consultations were available with a GP, nurse, and health care assistant until 8pm every Tuesday evening to enable improved access for working patients.
- Telephone consultations and advice were offered each day when this was appropriate, so that patients did not always have to attend the practice for a face-to-face consultation.
- The practice offered on-line booking for appointments and requests for repeat prescriptions. Participation in the electronic prescription scheme meant that patients on repeat medicines could collect them directly from their preferred pharmacy.
- Health reviews were available for new patients, and for those aged between 40-75 as part of the NHS health check programme. Services such as smoking cessation, and input from a health trainer from the 'Live Life Better Derbyshire' scheme promoted healthier lifestyles.
- The practice actively promoted health screening programmes to keep patients safe. The practice's uptake for the cervical screening programme was 86.3%, which was above the CCG average of 84.1% and the national average of 81.8%. Uptake of bowel and breast cancer screening was also higher than local and national averages.
- The practice offered out of area registrations for patients, which allowed them to access the service closer to their place of work.

People whose circumstances may make them vulnerable

Good

- Patients with end-of-life care needs were reviewed at a monthly multi-disciplinary team meeting including a lead GP, district nurses, a Macmillan nurse, and a matron from a local care home. Some of these patients were also reviewed at the fortnightly multi-disciplinary meetings if their care package needed closer monitoring, with input from the wider care team.

Summary of findings

- The community matron developed care plans for the most vulnerable patients including those at end of life. A specific template was used to ensure key information was available to the ambulance service, the out of hours' provider, and social services to ensure continuity of care for the patient. This included the patient's preferred place of care and whether a Do Not Attempt Resuscitation order was in place.
- The practice had identified 2.4% of their registered patients as carers. The community matrons and care co-ordinator identified carers as part of their work with vulnerable patients, and new patients were identified as part of the registration process. Information on various support agencies and groups was available.
- Staff had received adult safeguarding training and were aware how to report any concerns relating to vulnerable patients. There was a designated lead GP for adult safeguarding.
- The practice had undertaken an annual health review for 20% of their patients with a learning disability in 2014-15. The practice recognised this needed improvement and the team had discussed ways to address this. Figures for the first six months of 2016-7 showed that 12% of patients had been seen for an annual review at the time of our inspection.
- The practice had signed up to be a safe haven for vulnerable people. Any person in need could enter the practice as a point of refuge until they could be safely collected by relatives or carers.
- The practice had low number of patients whose first language was not English. These patients were able to access interpreter services in person or by telephone if required.

People experiencing poor mental health (including people with dementia)

Good

- The practice achieved 96.5% for mental health related indicators in QOF, which was 1.6% below the CCG and 3.7% above the national averages. This was achieved with lower exception reporting rates at 7% compared against local (14.5%) and national rates (11.1%).
- 84% of patients with severe and enduring mental health problems had a comprehensive care plan documented in the preceding 12 months according to 2014-15 QOF data. This was below the CCG average of 93.2% and the national average of 88.5%, but with much lower levels of exception reporting at 7.4% (CCG 17.4%; England 12.6%)

Summary of findings

- The practice worked closely with local community mental health teams and representatives regularly attended the multi-disciplinary team meetings.
- The practice told patients experiencing poor mental health and patients with dementia about how to access local services, support groups and voluntary organisations. Information was available for patients in the waiting area.
- There was access to counselling and associated talking therapies' services on site. Patients could self-refer to this service.
- 87.2% of people diagnosed with dementia had had their care reviewed in a face-to-face meeting in the last 12 months. This was above local and national averages by 3% with lower exception reporting rates at 6%, compared to local and national averages of 8.3%.
- Staff had received dementia awareness training from the Alzheimer's Society at a team meeting. The practice planned to achieve 'Dementia Friendly' status before the end of 2016.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016 and the results showed the practice was generally performing above or in line with local and national averages. There were 240 survey forms distributed to patients, and 122 of these were returned. This was a 51% completion rate of those invited to participate, and equated to 1.2% of the registered practice population.

- 88% of patients found the receptionists at this surgery helpful compared against a CCG average of 89% and a national average of 87%.
- 87% of patients said they would recommend this surgery to someone new to the area compared to a CCG average of 84% and the national average of 78%.
- 88% of respondents said the last nurse they saw or spoke to was good at listening to them compared to a CCG average of 94% and the national average of 91%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 comment cards which all contained extremely positive feedback about the care provided by the practice team. Many of the cards included accounts of how individual members of the practice team had provided exemplary treatment and support for patients. Patients wrote that they were treated in a dignified and respectful manner; that they were given sufficient time to discuss their concerns; and that they always felt listened to during their consultations. Many patients commented that the standards of cleanliness at the practice were always excellent. Three of the comment cards included minor grumbles; two of which related to the recent availability of appointments, and one was about a perceived lack of privacy at the reception.

We spoke with 12 patients during the inspection who provided positive feedback regarding the caring and compassionate approach adopted by the practice team. Patients reported a high level of satisfaction regarding their consultations, stating that they were provided with information about their conditions and the available treatment options when this was appropriate. Patients mostly told us they were satisfied with the appointment system, and that they were usually kept informed if clinics were running late.

Dr DJ Collins' Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr DJ Collins' Practice

Dr DJ Collins' Practice (also known as The Springs Health Centre) provides care to approximately 9,900 patients in the village of Clowne, in the Bolsover district of North Derbyshire. It is located approximately nine miles from the town of Chesterfield.

The practice provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The practice operates from a modern purpose built two-storey building constructed approximately ten years ago. All patient services within the practice are provided on the ground floor of the building, whilst the upper floor is utilised for administration.

The partnership was originally formed in 2000, and by 2004 had expanded to replace three former locally based practices. The practice is now run by a partnership of five GPs (three males and two females) who employ two female salaried GPs. The Springs Health Centre is a training practice and supports placements for GP registrars (this is a qualified doctor who is undertaking additional training as a GP). There was one GP registrar in post at the time of our inspection. The practice also hosts visiting medical students.

The nursing team consists of one male and one female nurse practitioner, five practice nurses and three health care assistants. The partners employ two community matrons (one of whom has a dual role as a practice nurse), and a care co-ordinator. The clinical team is supported by a practice manager, an office manager and a reception manager, who oversee a team of 13 administrative and reception staff. The practice employs their own domestic services' team consisting of five staff, headed by a caretaker.

The registered patient population are predominantly of white British background. The practice age profile shows slightly higher numbers of people aged over 45, and lower numbers of under 15 year olds, when compared against the national average. The practice is ranked in the fifth more deprived decile and serves a mix of rural and semi-rural areas. Due to the previous mining history in the area, there is a higher prevalence of some industrial-related illnesses. Deprivation scores (2015) at 22.1 were in line with the national average (21.8), but above local rates (18). Due to the proximity to the M1 motorway and the relative affordability of newer housing developments, the area had attracted commuters, which had reduced the local level of deprivation and unemployment in more recent years.

The practice opens Monday to Friday from 8am until 6.30pm, with additional extended hours being provided each Tuesday evening when the practice is open until 8pm. The practice closes at 1.30pm on one Wednesday afternoon each month for staff training.

GP consultations commence each morning from 8.30am until 10.30am, and then from 11.30am until 12.30pm. Afternoon GP surgeries run between 3.30pm until 5.30pm.

Detailed findings

There is a duty doctor available every day and they will see patients until 6.30pm. The last GP appointment during extended hours on Tuesday evenings is available at 7.40pm.

The practice has opted out of providing out-of-hours services for its own patients. When the practice is closed, patients with urgent needs are directed via the 111 service to an out-of-hours and walk-in urgent care centre in Chesterfield, operated by Derbyshire Health United (DHU).

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

We carried out an announced inspection on 28 September 2016 and during our inspection:

- We spoke with staff including GPs, a nurse practitioner, the practice manager, the care co-ordinator, and a selection of reception and administrative staff. In addition, we spoke with managers at three local care homes, the health visitor, the district nursing team leader, and the CCG's medicines management technician regarding their experience of working with the practice team. We also spoke with 12 patients who used the service, and three members of the patient participation group.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Fourteen significant events had been reported over the course of the 12 months.
- Staff were encouraged to report incidents within a supportive 'no blame' culture.
- A significant event reporting form was readily available to all staff. Staff completed the form, or reported the incident to their line manager, who would then complete it. The staff member involved discussed the incident with their line manager and was provided with support if required.
- Completed forms were sent to the practice manager to assess the potential severity of the incident, and determine whether any urgent or remedial action was indicated to protect patients or staff.
- Completed incident forms were discussed by the practice's management team, which consisted of the GP partners, the practice manager and the nurse manager. Actions were agreed and undertaken in response to the incident.
- Patients received an apology and appropriate support when there had been an unintended or unexpected incident. The practice recognised their duty of candour and informed us they would either meet with the individual concerned or write to them, depending on the particular circumstances involved.
- When learning was identified following an incident, this was cascaded to relevant members of the practice team through clinical or administrative staff meetings. Documentation did not always fully reflect that actions had been completed. The practice was aware of this and had identified that this was an area they could strengthen in order to provide evidence that agreed actions had been fully completed.
- A GP collated a summary of incidents over a 12 month period. The practice planned to commence an annual review of events with the full practice team to consider any recurrent themes that may have emerged, and to ensure that all actions had been completed.
- We saw examples of learning that had been applied following a significant event, and this was extended outside the practice when relevant to enhance patient care. For example, there had been an incident in which a patient in a care home had not received medicines to control their condition for three days. This was identified by a member of the practice team, and the community matron then attended the home and delivered training to the care home staff to highlight the importance of administering the medicine, and explained why this needed to be closely monitored.

The practice had a process to review alerts received including those from the Medicines Health and Regulatory Authority (MHRA). A nurse practitioner reviewed new alerts to sift out those which were not applicable, and then cascaded the appropriate alerts onto the clinical team. Outcomes were recorded within the file name of the alert, which was then saved onto the practice computer system for reference. When concerns were raised about specific medicines, patient searches were undertaken by the medicines management team to identify which patients may be affected. Action was taken to ensure patients were safe, for example, by reviewing their prescribed medicines.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local guidance. Practice safeguarding policies were accessible and up-to-date, and codes and alerts were used on the patient record to identify vulnerable children and adults. There was a designated lead GP for safeguarding both children and adults, who had received training at the appropriate level in support of their lead role.
- The health visitor and the midwife attended a meeting with the lead GP approximately every six weeks to discuss any child safeguarding concerns. Any relevant new information would be updated within the patient record, and minutes of the meeting were available. We spoke with a member of the health visiting team who informed us that there was effective liaison with the practice, and that they worked in collaboration should any issues be identified. We were told that the GPs operated an 'open door' policy and were easily accessible to discuss any issues that arose in-between

meetings. The health visitor also told us that when they encountered a medical problem in a patient, the GPs were very responsive and arranged to see the patient quickly to provide effective treatment.

- Practice staff demonstrated they understood their responsibilities for safeguarding and all had received training relevant to their role. We were provided with a recent example where a GP had taken action when safeguarding concerns had been identified to ensure the safety and welfare of the child.
- Vulnerable adults were monitored by the practice team and staff were aware how to report any safeguarding concerns regarding adults. Members of the practice team were able to describe how they had acted to safeguard adults when concerns had been identified.
- A notice in the reception and the consulting rooms advised patients that a chaperone was available for examinations upon request. Members of the reception and administration team had received training from the nurse practitioner in support of this role, and some staff had also completed on line training. Staff who undertook chaperoning duties had received an appropriate disclosure and barring check (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). A practice chaperone policy was available.
- We observed that the practice was maintained to high standards of cleanliness and hygiene. A nurse practitioner was the appointed infection control lead. There was no evidence of recent update training available to support the lead role, although the nurse informed us that they would source an appropriate course. There were some infection control policies in place, including needlestick injuries and the management of spillages. Infection control audits were undertaken every six months, most recently in September 2016, and this was supported by documented actions to address the identified issues. The audit was discussed at the nurses' meeting and this was evidenced through minutes produced from the meeting. We observed that an action identified in the previous audit had not been fully resolved, as it was again highlighted as an issue in the most recent audit. Audits on minor surgery, joint injections and contraceptive implants incorporated a measure of post-procedure infections, and these demonstrated that there had been no reported infections. Practice staff received information on infection control as part of new staff inductions, and on-line training was available.
- The practice employed four part time housekeeping staff managed by a caretaker. A written schedule of daily, weekly and monthly cleaning tasks were available for each room, and robust arrangements were in place to monitor cleaning standards. There was regular liaison in place between the caretaker and office manager to ensure any problems were dealt with promptly and effectively. Documentation was available to support the control of substances hazardous to health.
- We reviewed three staff files and found that the necessary recruitment checks had been undertaken prior to commencing work with the practice. For example, proof of identification, qualifications, registration with the relevant professional body and the appropriate checks through the DBS.
- We saw evidence that clinical staff had received vaccinations to protect them against hepatitis B. Non-clinical staff had been offered this vaccination, and most staff had received this, although the practice operated a 'no touch' policy with reception staff. All new starters received a health assessment via the local occupational health service.

Medicines management

- The arrangements for managing medicines in the practice, including emergency medicines and vaccinations were mostly safe. However, we observed that the vaccine fridge temperature was not always logged on each afternoon. Although the temperatures were only required to be checked and recorded each day the practice opened, the practice was undertaking this twice each day, but occasional afternoon recordings had not been logged.
- Blank prescription forms and pads were securely stored, although the practice needed to ensure a more robust system was in place to monitor the distribution of prescriptions within the practice. The practice acknowledged this and provided us with a revised protocol for the storage and security of prescriptions, following our inspection. This included a log sheet to record distribution within the practice.
- There was a process in place to support the safe issue of repeat prescriptions.

Good

Are services safe?

- Systems were in place to monitor patients prescribed high-risk medicines. All of these medicines were prescribed as acute medicines to ensure all prescriptions for issue were checked individually by a GP.
- Regular medicines stock checks including expiry dates were undertaken.
- Signed and up-to-date Patient Group Directions were in place to allow nurses to administer medicines in line with legislation, and healthcare assistants administered medicines against a patient specific prescription or direction from a prescriber.
- Uncollected prescriptions were monitored every month. Any uncollected prescriptions were reviewed by the duty doctor who took a clinical decision on an individual basis as to whether any further action was indicated.

Monitoring risks to patients and staff

- A practice health and safety policy was available and the practice fulfilled their legal duty to display the Health and Safety Executive's approved law poster in a prominent position.
- As the practice was located with the community health services provider within a shared building, the two parties had agreed defined individual responsibilities for health and safety.
- Regular checks of the practice environment were undertaken that incorporated cleanliness, room temperatures, and obstacles in thoroughfares. This included a weekly checklist reviewed and maintained by the caretaker. In addition, the practice or office manager carried out an annual site check and produced an action plan of any work that was identified as being required. Any building issues or faults were recorded in a book for the caretaker to action. We saw that issues were responded to promptly and recorded and dated by the caretaker as completed.
- There were some generic risk assessments available, although this process was not being used proactively to manage any new or emerging risk areas. For example, by adding any new risk areas that may have been identified through the incident reporting procedure.
- A fire risk assessment had been undertaken in January 2016. This had resulted in an action plan and we saw evidence that the practice had responded to all the issues that had been identified. Fire alarms, emergency lighting, and extinguishers were tested and serviced regularly to ensure they were in full working order. Staff had received annual fire training, and the practice undertook trial evacuations every six months to ensure staff were aware of the procedure to follow in the event of a fire.
- All electrical equipment was regularly inspected to ensure it was safe to use, and medical equipment was calibrated and checked to ensure it was working effectively. We saw certification that this had been completed by external contractors in the last 12 months.
- The practice had a documented risk assessment for legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings). We saw evidence that infrequently used water sources were run regularly as a control measure, and this was supported by documentation.

- There were arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. Rotas were organised six weeks in advance and any problems were reviewed via the daily management team meeting. The practice did not use locums, and would arrange for cover between their own team, for example, by amending working patterns or cancelling administration sessions.
- The practice had a system to manage incoming correspondence to ensure that any actions, such as a change to a patient's medicines, were completed promptly. This was audited to provide assurance that the system was working effectively.

Arrangements to deal with emergencies and major incidents

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

- Staff had received annual basic life support training. One of the nurse practitioners was an advanced life support instructor and delivered separate annual training sessions to clinicians and administrative staff.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. An extra oxygen cylinder was available as a back-up.
- Emergency medicines were easily accessible to staff in a secure area of the practice and were in date.
- An emergency alert system on telephones informed staff to assist rapidly with any emergency situation, such as if

a patient was to collapse. We were provided with examples of when an emergency had arisen, and were informed how this was handled via a co-ordinated and effective response by the practice team.

- The practice had a business continuity plan for major incidents such as power failure or building damage.

Alternative sites had been identified for temporary surgeries should the building become unavailable for any reason. This was regularly reviewed, most recently in August 2016. Copies of the plan were kept off site in case any incidents made the site inaccessible.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and local guidance. Access to a web based programme gave instant access to clinical information. Practice protocols developed by the Joint Area Prescribing Committee were available based upon NICE guidelines, for example, there was a protocol to be followed for patients with hypertension.

New guidance was discussed at weekly clinical staff education sessions, which were used to create an environment of learning within the practice. These sessions were also utilised for other learning opportunities such as feedback from courses, significant events, and audits.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2014-15) were 96% of the total number of points available, which was 2.1% below the CCG average, but 1.3% higher than the national average. Exception reporting rates at 8.5% were below the local average of 11% and the national average of 9.2%. Exception reporting is the removal of patients from QOF calculations where, for example, a patient repeatedly fails to attend for a review appointment. A low figure for exception reporting usually demonstrates a proactive approach from the practice to engage patients in attending for regular reviews of their condition.

QOF data from 2014-15 showed:

- Performance for diabetes related indicators was 84.3%, which was lower than the CCG average of 96.7% and the national average of 89.2%. However, there were lower exception reporting rates at 8.8% (local 13.4%; national 10.8%)
- The practice achieved 93.7% for clinical indicators related to chronic obstructive airways disease. This compared to a local average of 99.2% and a national average of 96%, but with slightly less exception reporting by the practice.
- QOF achievement for 2014-15 for asthma was 100% which was slightly higher than local and national averages (97.6% and 97.4% respectively). However, exception reporting rates were very high at 28.1% (local 9.6%; national 6.8%).
- Dementia related indicators scored 99.1%. This was 1.3% above the CCG average and 4.6% higher than the national average. Exception reporting rates were approximately 3% below local and national averages.
- Exception reporting was generally low, although we observed that there were high levels of exception reporting for asthma and depression. The practice was able to explain why these rates were higher and a sample of records indicated that patients were being appropriately exception reported. The practice explained that high exception reporting in asthma was because they were mainly younger patients who had received three invitations, and had either not attended, or expressed that they did not want to attend.

Practice supplied data (subject to external verification) demonstrated that high QOF achievement at 96% had been maintained in 2015-16.

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

- We saw that sixteen clinical audits had been undertaken in the last year, including some full-cycle audits where changes had been implemented and monitored with positive outcomes for patients. We reviewed a full cycle audit undertaken on patients with atrial fibrillation (an irregular heart rate), and the prescribing of an appropriate anticoagulant medicine (anticoagulants are medicines that prevent the blood from clotting as quickly or as effectively as normal) to reduce the risk of having a stroke. The second cycle audit showed that patients had been identified and reviewed to ensure they were receiving the most appropriate medicines for their condition. This audit was followed by the development of a comprehensive and informative patient advice sheet on anticoagulant medicines.
- The practice worked with a CCG medicines management pharmacy technician who regularly visited

Good

Are services effective?

(for example, treatment is effective)

and carried out medicines audits to ensure prescribing was cost effective and adhered to local guidance. The technician had undertaken a project on deprescribing with the community matron which had a significant impact on patient outcomes by ensuring they stopped taking medicines they no longer required, and had their individual medicines regime reviewed to ensure it met their personal requirements. This project also produced significant cost savings. We also saw a medicine reconciliation audit that measured the efficacy of procedures in transferring changes to medicines onto primary care patient records following a hospital admission, to ensure patient safety. The audit provided assurance that GPs acted promptly to effect changes as directed within discharge summaries.

- The practice participated in local benchmarking activities. For example, they participated in annual quality focussed visits with the CCG to review comparative data including referral rates and hospital admissions. Data demonstrated that the practice was one of the lowest referrers within their CCG. This reflected the way the practice worked in managing patients' needs in house whenever possible, for example by internal referral to a GP with a special interest or expertise, or the consideration of different treatment options. The practice had worked with their local acute hospital to access e-mail support for specialist advice. This ensured a response within 72 hours and facilitated patient management, and the potential avoidance of a referral into secondary care.

Effective staffing

- The practice had reviewed the needs of their patients and created a skill mix within their team to provide optimal patient care. The skill mix of the team included:
- Two nurse practitioners who provided on-the-day assessment and care for patients presenting with new conditions, and minor injuries and illnesses. The nurse practitioners were able to examine, diagnose and prescribe medicines for a range of conditions, creating more capacity for the GPs to manage complex conditions.
- Two community matrons who actively sought potentially vulnerable people and organised care and support to keep patients in their own homes. This included planning safe and early hospital discharges to ensure the individual had the care they required when they returned home. The matrons received referrals from many different sources, including concerned relatives or neighbours. The matrons provided bereavement support, and also provided regular input into three local care homes.
- A care co-ordinator who supported vulnerable patients, worked alongside the community matrons. This included arranging regular meetings to review care plans and individual support packages.
- The practice provided an induction programme for all newly appointed staff. We reviewed examples of these which were specific to individual roles, and we saw evidence that topics were signed off once completed. Staff told us they were well supported when they commenced their roles with shadowing opportunities and had easy access to support from their colleagues.
- Staff told us that they received an annual appraisal and we saw documentation that evidenced this. This included a review of the previous year's performance, and the setting of objectives and the identification of learning for the forthcoming year. We spoke to members of the team who informed us of how learning opportunities had been discussed during the appraisal and supported by the practice. For example, a member of the team informed us how they had discussed formal coding training at their appraisal and the practice had agreed to support this.
- The practice ensured role-specific training with updates was undertaken for relevant staff including taking samples for the cervical screening programme. Nurses received regular immunisations updates in-house but did not attend external training. In accordance with Health Protection Agency standards for immunisation training, the practice agreed to source appropriate course for their nurses at the earliest opportunity.
- Staff received mandatory training that included safeguarding, fire safety awareness, and basic life support. Staff had access to and made use of e-learning training modules and in-house training. The practice had protected learning time on one afternoon each month, when in-house training was organised for the practice team. GPs attended training events organised by their CCG on some of these months. We observed that the practice maintained a record of staff training and reviewed this to ensure update training was scheduled in advance.

Good

Are services effective?

(for example, treatment is effective)

- Training and development was encouraged at all levels. The practice had participated in the local college apprenticeship scheme for administrative and reception roles, and this had resulted in the successful recruitment of two trainees.
- Four of the nurses were independent prescribers. They were able to access GPs for advice if this was required, and also received feedback from the local prescribing leads' meeting via the practice's lead GP for prescribing. All prescribers within the practice team were invited to attend an annual prescribing review with the CCG's medicines management team.

Coordinating patient care and information sharing.

- The information needed to plan and deliver care and treatment was available to clinicians in a timely and accessible way through the practice's electronic patient record system. This included care plans, medical records, and investigation and test results. We viewed examples of care plans and saw that these were comprehensive and appropriate. Summary care plans for vulnerable patients were accessible by the ambulance services and the out of hours service to ensure continuity of care outside of the practice.
- Fortnightly multi-disciplinary meetings were held at the practice to assess the range and complexity of patients' needs, and to plan ongoing care and treatment for vulnerable patients including those at high risk of hospital admission. This meeting included members of the practice team, and others including a social worker, district nursing team staff, a physiotherapist, an occupational therapist, and a representative from the community mental health team. Others would attend if there was a relevant patient to be discussed – this included environmental health, the benefits agency, the falls service, and a police community support officer. Providers of different community based services were sometimes invited to attend this meeting to raise awareness of what was available, and to establish effective communication channels. Minutes were produced from the meeting and individual patient notes were updated with any important information arising from the discussions.
- Monthly meetings were held to focus specifically upon the needs of end of life care. These were chaired by a lead GP and included attendance from the community matron, district nursing team, the Macmillan nurse, and representatives from care homes. Patient deaths were analysed at these meetings and any learning points were identified to benefit future care delivery.
- Nursing staff had their own additional monthly meeting. We observed from the most recent minutes that the nursing team were advised on updates to the vaccination programme, and informed that the file containing Patient Group Directions (PGDs) had been updated and all nurses would need these signed and countersigned before administering any medicines via a PGD.
- Each morning at 11am, all GPs, the nurse practitioners and the practice manager met for a coffee break. This provided an opportunity for an informal meeting to share information or discuss any issues which had arisen during morning surgery. The meeting also gave the team allocated time to see each other and ensure they had a break from their routine work.

Consent to care and treatment

- Staff sought patients' consent to care and treatment in line with legislation and guidance.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs).
- When providing care and treatment for children and young people, staff followed national guidelines to assist clinicians in deciding whether or not to give sexual health advice to young people without parental consent.

Supporting patients to live healthier lives

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

- The practice hosted two sessions each week provided by the 'Live Life Better Derbyshire' service. This offered assessments for patients over 16 years of age to provide advice and signposting to relevant support schemes, for example, to stop smoking and to assist in weight management and promote more active lifestyles.
- The practice provided new patient health checks, and NHS health checks for patients aged 40-74. Practice data showed that 61% of the 475 patients offered a NHS health check during 2015-6 had been seen.

Good

Are services effective?

(for example, treatment is effective)

- The practice's uptake for the cervical screening programme was 86.3%, which was above the national average of 81.8%, and the CCG average of 84.1%. Exception reporting was in line with local and lower than national percentages. The successful performance in the cervical screening programme was achieved by the use of a robust recall system, aided by clinicians working opportunistically to encourage patients to be screened.
- National screening programme data showed the uptake for bowel cancer screening was in line with local averages, and slightly higher than national averages. The practice tried to motivate patients to receive screening if it was observed that they had refused the test. Breast cancer screening was higher when compared with local and national averages. This was aided by a mobile mammography unit that visited the site for approximately four weeks each year.
- Childhood immunisation rates for the vaccinations given to children aged up to five years of age were high and marginally above local averages. The overall childhood immunisation rates for the vaccinations given to under two year olds ranged from 98.1% to 100% (local average 95.2% to 98.9%) and five year olds from 94.7% to 100% (local average 96.5% to 99.1%).
- However, the number of patients with a learning disability receiving an annual review during 2014-15 was low at 20%. The practice was aware of this and were taking steps to improve this.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

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

Feedback received via comment cards, and from patients we spoke with on the day, told us that patients felt listened to and that they received the right care and treatment at the right time from staff. Patients consistently said that they were treated with compassion, dignity and respect by clinicians and the reception staff. Results from the national GP patient survey in July 2016 showed the practice was in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 90% of patients said the last GP they saw or spoke to was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 86% of patients said the last GP they saw gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to a CCG average of 94%, and the national average of 91%.

We spoke with community-based staff and care home staff who told us that the practice team were patient-centred, accessible, and respectful of their opinions.

We were provided with examples of how the practice provided ongoing care and support to their most vulnerable patients. One of the community matrons had been a finalist for a recognition of care award within the CCG.

Care planning and involvement in decisions about care and treatment

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

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

- 91% of patients said the last GP they saw was good at explaining tests and treatments in line with the CCG average of 91% and above the national average of 86%.
- 82% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87%, and the national average of 82%.

Patient and carer support to cope emotionally with care and treatment

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

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

The practice had coded 2.4% of the practice list as carers. The practice identified new carers upon registration, and the team were able to signpost them to various support agencies and groups. The community matron and care co-ordinator proactively identified carers as part of their work with the practice's most vulnerable patients. A carer/patient experience questionnaire had been undertaken focusing on the community matron caseload in December 2013 to consider any areas for development. There were plans to repeat this in the future. The practice encouraged carers to receive vaccination against the flu virus. A representative from the local Carers Association was invited to attend the annual flu clinic to promote carer support. We observed that information for carers was available in the reception area.

The practice worked with the wider multi-disciplinary team to deliver high quality end of life care for patients. The

Good

Are services caring?

practice had adopted the Gold Standards Framework (GSF), which is a systematic, evidence-based approach to optimising care for all patients approaching the end of life. Advanced care planning was undertaken at the earliest opportunity to ensure that patients' preferred wishes were taken into account. Practice data demonstrated that all expected patient deaths within the previous six months, had a preferred place of care documented. All deaths were subject to an after death analysis within the practice to identify any learning points for the future. For example, the practice had identified the need for care homes to report any new admissions to them immediately, in order to assess patients at the earliest opportunity to include advanced care planning arrangements. A representative of the district nursing team informed us that GPs were easily accessible and responded effectively to any requests for support in the ongoing care of patients with palliative care needs.

Following a patient death, a card was sent from the practice to offer condolences. The community matron would undertake a visit to relatives or carers to offer bereavement support, and further follow-up support visits would be arranged if these were required. The matron would also attend patient funerals when the team had provided significant input. Information was available to signpost relatives or carers to appropriate services such as counselling where indicated.

A manager at a care home informed us how a GP had spent a long time with the relatives of a new patient who was receiving end of life care, to support them and fully explain the patient's particular circumstances. The GP managed to alleviate the relatives' concerns by the caring approach adopted. This manager also attended the practice's palliative care and multi-disciplinary team meetings which had been very helpful. For example, the manager was able to explain how the home had been able to respond more appropriately to the end of life needs for one of their residents and help them to achieve a peaceful death, as a result of attending one of these meetings.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG), to secure improvements to services where these were identified. For example, the CCG had funded the community matron to work one day each week with the CCG's lead medicines management technician on a deprescribing project. The outcome of the project resulted in significant cost savings and reviews of 154 patients' medicines' regime to ensure they had medicines stopped, reduced, changed or initiated to best meet their needs.
- The practice provided a range of services that ensured these were easily accessible for their patients. This included phlebotomy (taking blood); ECGs to test the heart's rhythm; monitoring of patients prescribed medicines to thin their blood; blood pressure checks; family planning services (including coil and implant procedures); travel vaccinations; smoking cessation support; and performed some limited minor surgery including joint injections.
- The partners had purchased a centrifuge. This equipment allowed for blood samples to be taken throughout the day, offering improved access for patients. Prior to this, patients would need to attend before 1pm to ensure their blood was transported to the laboratory before it clotted, and therefore could not be tested.
- The practice offered a full range of contraception services. Appointments were available all week, rather than being confined to a specific clinic. The duty GP ensured emergency contraception was readily available on the day. The practice had pioneered a system with the local school so that the child could present a red or blue card at reception without having to explain any details. The different coloured cards denoted either a request for emergency or routine contraception.
- A GP led an enhanced service for GP shared care substance misuse. Five patients were receiving this service at the time of our inspection, and this ensured patients were able to attend a familiar and local environment to access the care and support they required.
- All of the practice's consulting rooms were accessed on the ground floor. The site was easily accessible for patients with reduced mobility, and a hearing loop system was available within reception for patients with a hearing impairment. A lowered area in the reception desk made it easier for patients in a wheelchair to talk to reception staff.
- The practice hosted some services on site to facilitate better access for patients. This included counselling services and talking therapies for patient experiencing mental health difficulties; the abdominal aortic aneurysm screening; the diabetic retinopathy service; the Citizens Advice Bureau; audiology services; alcohol counselling services; and the mammography unit (for breast screening). Patients also had access to a private chiropractor on site.
- The co-location of the GP practice with the community health service's provider meant that patients could access a number of services on site including podiatry, physiotherapy, and a community dental service. It also meant that practice staff had excellent access to district nurses, health visitors and the community midwife who had bases within the building. An independent pharmacy was located next door to the practice.
- The waiting area contained a good range of information on local services and support groups. This included information for carers, and local services available for patients with mental health issues. Health promotion material was displayed within the waiting area, and this was updated regularly. The practice was actively promoting the next flu campaign at the time of our inspection.
- A log in touch screen was available for patients upon arrival. The CCG had agreed to fund a patient information screen for the practice, and this was awaited in the near future.
- Same day appointments were available for children and those patients with medical problems that required them to be seen urgently. Home visits were available for older patients and others with appropriate clinical needs which resulted in difficulty attending the practice.
- The practice provided care for residents at three care homes for older patients, some of whom had dementia. A community matron visited each home for one morning every week, and a GP undertook a separate fortnightly visit to each home. All residents received regular reviews, and care plans were in place for all patients. Managers at the homes informed us they were

Good

Are services responsive to people's needs?

(for example, to feedback?)

highly satisfied with the service received and the care provided for their residents. The GP formally reviewed the service every three months with the care home manager to check if everything was working well.

- The practice had delivered training to staff in local care homes to benefit patient care. This included monitoring of medicines, and the recognition of symptoms of delirium.
- A spacious reception area helped to promote confidentiality. If patients became distressed or wished to discuss a sensitive issue, they could be moved into a room located besides the main reception desk.
- Patients could order repeat prescriptions on line. The practice participated in the electronic prescription service, enabling patients to collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- Translation services were available for patients whose first language was not English.

Access to the service

The practice opened daily from 8am until 6.30pm with extended hours opening until 8pm on a Tuesday evening for both GP and nurse appointments. The practice closed on one Wednesday afternoon each month for staff training.

GP consultations commenced each morning from 8.30am until 10.30am, and then from 11.30am until 12.30pm. Afternoon GP surgeries were provided between 3.30pm until 5.30pm. A duty doctor was available every day who saw patients until 6.30pm. The last GP appointment during extended hours on Tuesday evenings was available at 7.40pm (7.30pm with the practice nurse, and 7.40pm with the health care assistant).

The practice had previously provided Saturday morning appointments but due to poor uptake this was not continued. Patients preferred the availability of a late evening clinic.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above or in line with local and national averages.

- 86% of patients found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 85% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 88% and a national average of 85%.
- 80% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 72% of patients usually got to see or speak to their preferred GP, which was higher than both the CCG average of 60% and the national average of 59%.
- 77% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 72% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 71% and a national average of 65%.

On the day of our inspection, we saw that the next available routine GP appointment was available that day, and other appointments were free towards the end of the week.

Most GP appointments were bookable up to three months in advance and the majority of appointments to see the nurse practitioner were released each day. When this was at capacity, patients who requested an on-the-day consultation were placed on a telephone advice slot, usually with the duty GP. Patients who still required to be seen that day after the call were then given an appointment to see a clinician, and this would normally be the duty doctor.

Listening and learning from concerns and complaints

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

- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated person that co-ordinated the complaints process. Clinicians always reviewed any complaints of a clinical nature.
- We saw that information was available to help patients understand the complaints system. This was also provided within the practice leaflet and on the practice's website.

We looked at eight complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency.The practice offered to meet with

Good

Are services responsive to people's needs?

(for example, to feedback?)

complainants to discuss their concerns whenever this was deemed appropriate. Complaints were sometimes incorporated into the significant incident review process to ensure greater analysis of the factors that led to the complaint being raised. Lessons were learnt and shared with the team following complaints, and action was taken to as a result to improve the quality of care. For example, the practice had received a complaint with regards the outcome of a particular consultation as the complainant did not feel that the problem had been effectively considered. This resulted in the patient being seen again by a GP with a specialist interest and expertise in the presenting issue, and follow up action being taken. This learning highlighted was for all members of Clinical Team to be aware of limitations in their clinical knowledge, and to consult with each other to prevent similar scenarios occurring in the future.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

- The partnership had developed aims and objectives. The practice ethos was to provide friendly, accessible services ensuring continuity of care, and to work collaboratively within a wider health community to provide quality care closer to home.
- The management team were able to articulate their key priorities, which formed their basis of their future strategic direction. There was a clear vision for the future which reflected the team's passion for continuous quality improvement.
- New ways of working were embraced to adapt to emerging demands. The practice was actively involved in the CCG's 21st Century strategy to deliver joined up care closer to people's homes, and GPs had taken part in local consultation events to inform the strategic direction. As part of this, the practice had aspirations to extend their premises to enable the delivery of more patient services. They were also focused on a model of integrated working with community-based teams to optimise the care of patients.
- The practice worked with other local GP practices, and was part of a local GP federation which met each month and provided a collaborative forum for future service planning. The practice manager was one of five directors within the federation.

Governance arrangements

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

- There was a clear team structure in place, and staff were aware of their own roles and responsibilities. All GPs and nurses had defined lead clinical areas of responsibility.
- Systems were mostly in place for identifying, recording and managing risk, and implementing mitigating actions.
- A range of practice specific policies had been implemented, and were available to all staff.
- An understanding of the performance of the practice was maintained which included the analysis and benchmarking of QOF performance, and referral and prescribing data. Actions were undertaken when any variances were identified.

Leadership and culture

- There was a stable management structure within the practice, with the majority of partners and senior managers being in post for a number of years. Other members of the practice team had also been in post for a long time providing continuity, and well established relationships with patients and health and social care colleagues to deliver better care.
- Decisions were taken by the practice management team which consisted of the GP partners, the practice manager and the nurse manager. This demonstrated a more inclusive approach to decision making within the practice, rather than solely as a partnership. The practice held a monthly management team meeting to focus on key issues relating to the practice business, and these meetings were documented. All decisions were agreed collectively as a team.
- The practice were mindful of proactive succession planning arrangements. For example, options were already being considered to replace a GP who was planning to retire in 2017. This included new models of care such as the expansion of their nurse practitioner role to alleviate capacity on GPs.
- The partners and practice management were able to demonstrate they had the experience and capability to run the practice effectively to ensure high quality care. The passion to deliver quality was reflected in the practice becoming the 101st practice in the country to achieve the Royal College of General Practitioners' Quality Practice Award.
- All clinicians had defined areas of lead responsibility for particular clinical and managerial functions, and GPs had established areas of special interest including dermatology, cancer, and women's health.
- The practice proactively engaged with their CCG and worked with them to enhance patient care and experience. A GP sat on the CCG's Clinical Reference Group and was the CCG lead GP for cancer. One partner attended the monthly locality meetings with other local GP practices and CCG representatives, and other GPs attended the Clinical Governance Leads and Prescribing Leads meetings. The practice manager attended the local practice managers' meetings and the CCG's Primary Care Development Group. Due to the practice's location on the border of two CCGs, the management

Are services well-led?

Outstanding ☆

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

team had established links with the neighbouring CCG to ensure planning was joined up and met the needs of their patients who resided within the Hardwick CCG area.

- The partnership had recently achieved training practice status when a new partner became a GP trainer. This ensured the ongoing development of the practice, and promoted continued evaluation of their service. It also was in alignment with the practice's focus towards ongoing learning. We spoke with the GP registrar who informed us they were well supported with a timetabled debrief session after every surgery, and could access support or advice as and when required.
- Staff told us there was an open culture within the practice and said the partners and practice manager were visible within the practice and were approachable, and always took the time to listen to all members of staff. Staff said they felt respected, valued and supported by the partners and managers in the practice.
- Staff told us the practice held monthly meetings during their allocated protected learning time. They had the opportunity to raise any issues at these meetings and felt confident and supported in doing so. The team would meet together and use this as an opportunity to review incidents and participate in mandatory or other general training applicable to the whole team. Minutes from this meeting were documented.
- The practice team had held a 'Building Understanding and Trust' session in August 2016. Different staff groups reviewed the things that were done well, and highlighted issues where improvements could be made in a supportive environment. This produced a number of outcomes to improve patient experience and productivity across the teams. For example, it was identified that walk-in patients on the day would be asked to give as much detail as possible to the receptionist. The receptionist would then send an urgent task message to the duty doctor, who in turn would need to contact reception with clear instructions on what to do. This provided a more responsive and consistent approach with walk-in patients.
- Staff we spoke with told us that the practice was a good place to work, and the team supported each other to complete tasks. The practice team met outside of work for social events, although there had not been any recent team building events organised by the practice.
- The practice had established some links with their local community. For example, the Clowne Heritage Society arranged displays in the entrance foyer. The practice had also worked with a local a school to improve access to contraception.

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

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

- The practice had gathered feedback from patients through patient surveys; via complaints received; a suggestion box; and responses received as part of the Families and Friends Test (FFT). Results from the FFT were displayed within the waiting area. The most recent results indicated that 89% of patients would be 'extremely likely' or 'likely' to recommend the practice to their family and friends.
- The practice had a patient participation group (PPG) with a core membership of twelve members who regularly attended meetings every two months. The practice manager or a nominated deputy would always attend the PPG meetings, and a GP would usually try to be present. The practice did not have a dedicated PPG noticeboard within the reception area. Information about meeting dates were displayed on the practice website, but no minutes or details of outcomes the PPG had achieved were available. We spoke with three members of the PPG who described a positive relationship with the practice, although there was limited evidence that they were influencing change within the practice.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

The practice had a history of continuous improvement. Due to the partners' active involvement with the CCG, the practice was often an 'early adopter' site to pilot innovative ideas. For example, the practice was an early adopter of the Map of Medicine web tool to provide access to locally customised pathways, centrally controlled referral forms

Are services well-led?

Outstanding ☆

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

and clinical information during a consultation. Whilst this had some initial technical issues, the practice had persevered to develop the functionality of the system to benefit patient outcomes.