The Brimington Surgery

Quality Report

Church Street
Brimington
Chesterfield
Derbyshire
S43 1JG
Tel: 01246 273224
Website: www.brimingtonsurgery.co.uk

Date of inspection visit: 12 April 2016
Date of publication: 16/05/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Brimington Surgery on 12 April 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. Learning was applied from events to enhance the delivery of safe care to patients.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. The practice was committed to staff training and development and the practice team had the skills, knowledge and experience to deliver high quality care and effective treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. The practice analysed and responded to feedback received from patients. The practice had recently undertaken a survey with their local care homes which demonstrated a high level of satisfaction with the care they had provided.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they generally found it easy to make an appointment with a GP and urgent appointments were available the same day.
  - The practice ensured they engaged with vulnerable patients to provide them with the support they needed. This included having a more flexible approach to consulting with them to ensure they could receive the care they required.
- The practice had excellent facilities and was well-equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff told us that they felt supported by management.
  - The practice reviewed the skill mix of their team to meet their patients' needs. For example, they had appointed a community practice nurse to focus on patients that were previously managed by the community matron.

Summary of findings

- There was an active patient participation group which influenced practice developments. For example, introducing practice nurse appointments into the weekly extended hours' surgery.
- Risks to patients were assessed and well managed, although the practice had not been formally assessed for the control and management of legionella on site.

We saw two areas of outstanding practice:

- Brimington Surgery was the first GP practice in Chesterfield to receive the Derbyshire Dignity Campaign Award in February 2016, an initiative developed by the local County Council and CCG. This reflected the passion within the practice team to provide high quality care to their patients. The practice ensured this was maintained by reviewing one of the ten action points within the award in turn at each monthly staff meeting to review what they were doing, and agree what might be done to enhance this even further. We observed a strong and visible patient-centred culture in which staff were motivated and inspired to offer personalised care that promoted people's dignity.
- A 'Village Friends Group' had been established by the practice with support from their community matron, to support those patients who were bereaved. This had expanded to include patients who were socially isolated and also to include patients from other local GP practices. Activities including lunch clubs and theatre trips took place which provided an opportunity for social interaction and promoted a strong sense of local community.

The areas where the provider should make improvement are:

- The practice should ensure that health and safety related risk areas are kept under ongoing review with supporting documentation.

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

- There was an effective system in place for reporting and recording significant events, and lessons were shared to make sure actions were taken to improve safety in the practice.
- When any unexpected safety incidents occurred, people were provided with an explanation and an apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- The practice had robust recruitment procedures to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- Risks to patients and the public were generally assessed and well-managed including procedures for infection control and other site-related health and safety matters. The practice had not had a formal legionella risk assessment completed, but provided evidence that this had been arranged and would be finalised within a month from the inspection date.
- Risks to vulnerable patients with complex needs were regularly monitored by multi-disciplinary team meetings to provide holistic care and ensure patients' needs were met.
- Medicines, including vaccines and emergency medicines, were stored safely and appropriately with good systems to monitor and control stock levels.
- Patients on high risk medicines were monitored on a regular basis and actions were taken to review any medicines alerts received by the practice to ensure patients were kept safe.
- The practice had effective systems in place to deal with medical emergencies.
- The practice ensured staffing levels were sufficient at all times to respond effectively to patients' needs.

Are services effective?

Good

- The practice adhered to local and NICE guidance, for example when treating patients for the management of long-term conditions.
- Data showed patient outcomes were generally above average for the locality. The practice had achieved an overall figure of 100% for the Quality and Outcomes Framework 2014-15. This

Summary of findings

was 1.9% above the CCG average and 6.5% above the national average. However, the exception reporting rate at 15.5% was higher (local 11%; national 9.2%), although we saw evidence from data supplied by the practice that the level of exception reporting had reduced over the last 12 months.

- Clinical audits demonstrated quality improvement, and we saw examples of full cycle audits that had led to improvements in patient care and treatment.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. GPs had specific areas of interest including substance misuse and acted as a resource for their colleagues. All GP partners had lead responsibilities for clinical and managerial issues.
- All staff had robust role specific inductions, and had received a performance review in the last 12 months which included an analysis of their training needs.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs, in order to deliver care more effectively. This was supported by monthly meetings attended by a wide range of health and care professional staff.
- The practice had a strong commitment to staff development at all levels and fostered opportunities for individuals to enhance their skills within a supportive environment.
- Staffing needs were kept under review to ensure the needs of patients could be effectively fulfilled. For example, the practice had employed a community practice nurse to manage the caseload of patients previously seen by the community matron employed by the community health trust.

Are services caring?

Outstanding ☆

- The practice was the first in the area to receive the Derbyshire Dignity Campaign Award, which recognised high standards of patient care including privacy, respect and the recognition of carers. All staff worked towards a ten point plan as part of the award, and discussed each of the points in turn at the monthly staff meeting to strive towards continual improvement.
- We observed a strong and visible patient-centred culture. Staff were motivated and inspired to offer personalised care that promoted people's dignity. Staff treated patients with kindness and respect, and maintained confidentiality throughout our inspection.

Summary of findings

- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated they were treated with compassion, dignity and respect and felt involved in decisions about their care and treatment.
- Data showed that patients generally rated the practice in line with local and national averages in respect of care. For example, 91% said the GP was good at treating them with care and concern compared to the CCG average of 91%, and the national average of 85%.
- A 'Village Friends Group' had been established by the practice and the community matron to support those patients who were socially isolated and bereaved. This had evolved into an independent group which had become established within the local community to help those individuals in need of support.
- The practice adopted a flexible approach in dealing with vulnerable patients to ensure their individual needs were accounted for. This included seeing patients opportunistically at short notice in recognition that some patients were difficult to engage with health care.
- A member of the reception team had been assigned as the practice carer's lead. The local Carers' Association had held a promotion event at the surgery and planned a monthly visit to provide information and support services to carers. Plans were under consideration to offer weekly appointments to carers.
- Feedback from community based health care staff and care home staff was consistently positive with regards to the high levels of care provided by the practice team.
- The practice provided personalised care to those patients at end-of-life. Practice data showed that 80% of patients had died within their preferred place as a consequence of the planning and support offered by the practice working in conjunction with the wider health and social care teams.

Are services responsive to people's needs?

Good

- Routine GP appointments were usually available within two days, and urgent appointments were available on the day. The practice offered an extended hours' surgery on one evening each week between 6.30pm and 8pm. Patients could book a routine appointment up to four weeks in advance. Access was improved by a locum GP who provided additional capacity during the winter months.
- Comment cards and patients we spoke with during the inspection were generally positive about their experience in obtaining a routine appointment. This was reinforced by the

Summary of findings

national GP survey in January 2016 which found 81% patients described their experience of making an appointment as good. This was in comparison to a CCG average of 77% and a national average of 73%.

- The practice hosted a range of services on site which made it easier for their patients to access. This included a physiotherapy service; a weekly clinic provided by a consultant psychiatrist; a weekly Citizens Advice Bureau session to assist with benefits advice; and a visiting well-being worker to promote healthy lifestyles.
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The premises provided modern and clean facilities and were well-equipped to treat patients and meet their needs. The practice accommodated the needs of patients with disabilities, including access via automatic doors and the availability of a hearing loop. The partners maintained investment in their premises and had built an extension to improve facilities on site.
- The practice provided care for a large number of residents in four local care and residential homes. We spoke with staff in three of these homes who informed us that the practice was very responsive to their patients' needs. Urgent visits were done on the day when required and planned 'ward round' visits ensured patients were kept under regular review.
- Information about how to complain was available and the practice responded quickly when issues were raised. Learning from complaints was shared with staff to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they were offered a private room next to the waiting area.

Are services well-led?

Good

- The partners had a vision to deliver high quality care and promote good outcomes for patients. Practice values underpinned the practice's work and staff were clear about their responsibilities in relation to this.
- There was an overarching governance framework which supported the delivery of the values and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- The partners worked collaboratively with the CCG and with other GP practices in their locality
- The partners reviewed comparative data provided by their CCG and ensured actions were implemented to address any areas of outlying performance.
- There was a clear leadership structure and staff felt supported by management. The practice held regular staff meetings and held an annual away day for the practice team.
- The practice had developed a range of policies and procedures to govern activity
- The practice sought feedback from patients and staff, which it acted on to improve service delivery.
- The PPG helped inform practice developments, for example, by making nurse appointments available within the extended hours' clinic.

Summary of findings

The six population groups and what we found

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

Older people

Good

- The practice had generally higher disease prevalence and levels of deprivation, particularly affecting their older population. The practice was aware of these factors and accounted for this as part of their routine work.
- The practice provided personalised care for all their patients. Each patient was allocated a named GP responsible for the co-ordination of their care. The sense of continuity and patient-focused care was at the centre of the planning and delivery of services.
- The practice held monthly multi-disciplinary meetings to discuss the most vulnerable patients and those at risk of hospital admission. This facilitated planning and the co-ordination of care to best meet their patients' needs.
- The practice worked closely with the community matron and care co-ordinator to plan and deliver patient care. For example, the care co-ordinator tracked patients admitted to hospital to plan a safe discharge and co-ordinate services including referral to social care, community rehabilitation services, the falls groups, and voluntary services when required.
- The practice used bespoke care plans to provide clear information on individual care plans, including patient preferences. This information sharing with out of hours' services and other agencies provided co-ordinated care for patients, and helped to reduce the number of unnecessary hospital admissions.
- An annual flu clinic was held in the local village church. This helped to improve the uptake of flu vaccinations and provided a social event for the local community.
- Longer appointment times were available and home visits were available for those unable to attend surgery.
- The practice provided care to four local nursing and residential homes. A named GP provided regular visits to the care homes for continuity. The visits provided medical advice, reviews of patients' medicines, care planning, and the discussion of any safeguarding concerns. The practice responded to any urgent patient needs on the same day.

People with long term conditions

Good

- QOF achievements for clinical indicators were higher than CCG and national averages. For example, the practice achieved

Summary of findings

100% for diabetes related indicators, which was above the local and national averages of 96.7% and 89.2% respectively. However, exception reporting was higher in six of the ten indicators for diabetes, although practice-supplied data for the last 12 months showed that exception reporting levels had reduced.

- The practice undertook annual reviews for patients on their long-term conditions registers. The review occurred in the patient's birthday month and was monitored by the GPs who received lists of those due a medicines' review, to indicate the type and length of appointment required, to update their individual needs as appropriate.
- The annual reviews were co-ordinated to ensure that patients with more than one condition could be reviewed as part of one appointment.
- There were nurse-led clinics available to support patients with diabetes, asthma and chronic obstructive airways disease.
- The practice held in-house bi-monthly education sessions for new patients diagnosed with diabetes and for those identified as being at risk of developing the condition.
- The practice provided insulin initiation (teaching patients how to inject and manage their insulin regime) for patients with type 2 diabetes (type 2 diabetes occurs when the body doesn't produce enough insulin to function properly).
- The practice was committed in supporting the training of clinical staff to deliver excellent chronic disease management. For example, the practice was supporting a nurse to complete a nurse prescribing course, and the health care assistant had completed a course to enhance their skill set in supporting those patients with a long-term condition.
- The practice provided INR monitoring at the practice and within patient's homes. INR testing measures the length of time taken for the blood to clot to ensure that patients taking particular medicines were kept safe.
- The practice had developed their own patient advice and information leaflets including diabetes, spirometry (a breathing test), and the application of ear drops.
- A pharmacist from the CCG's medicines management team visited the practice weekly to assist with medicines audits, reviews of prescribed medicines, and offered prescribing advice and guidance.

Summary of findings

Families, children and young people

Good

- Regular meetings were held between the lead GP for child safeguarding and health visitors and midwives. The cases discussed were documented in patient records, and the meeting minutes were circulated to all GPs.
- Telephone advice was offered to parents, and appointments were provided outside of standard school hours.
- Six-week mother and baby post-natal appointments were provided by the practice. Although this was no longer part of the core GP contract, the practice continued to provide this service in recognition of the benefits provided for new mothers. Feedback provided by new mothers acknowledged their appreciation of this service.
- A family planning and sexual health drop-in clinic run by the GP and practice nurse took place each week between 4pm and 6pm.
- The practice provided baby changing facilities, and there was a small play area for younger children. The practice welcomed mothers who wished to breastfeed on site, and provided a private room for them upon request.

Working age people (including those recently retired and students)

Good

- The practice offered on-line booking for appointments and requests for repeat prescriptions. The practice provided electronic prescribing so that patients on repeat medicines could collect them directly from their preferred pharmacy.
- Extended hours' consultations were available one evening each week from 6.30pm to 8.30pm to accommodate the needs of working people.
- The practice offered health checks for new patients and NHS health checks for patients aged 40-74.
- The practice promoted health screening programmes to keep patients safe. For example, the practice had achieved a rate of 78.6% cervical screening for eligible women which was in line with the local average of 79.4%, and the national average of 81.8%.
- Health Trainer sessions were held each week for advice regarding diet, smoking, alcohol and exercise.

People whose circumstances may make them vulnerable

Outstanding

- The practice had undertaken an annual health review in the last 12 months for 65.5% of patients with a learning disability.

Summary of findings

- A bi-monthly ward round was undertaken at a local home for 32 adults with severe learning disabilities. Staff at this home described the practice's input as excellent and being highly supportive and responsive.
- The practice worked in–line with recognised standards of high quality end of life care. Palliative care was co-ordinated by a named GP working with the wider multi-disciplinary team. Bi-monthly palliative care meetings were in place between with GPs, district nurses and the Macmillan nurse. An analysis of patient deaths was undertaken for patients with cancer to ensure any learning points were considered, and ensure that best practice was shared with the whole team.
- The practice adopted a co-ordinated approach to care by the use of care plans, which ensured key information was shared with other providers such as the out of hours service.
- Longer appointments were offered to vulnerable patients when required
- Homeless people were welcomed to register with the practice. The practice provided care for residents at a local facility providing accommodation for those with a history of substance misuse or mental health difficulties, and ex-offenders. A more flexible approach was taken to see these patients, in recognition of them not regularly engaging with health services. The practice also worked with a local women's refuge team and facilitated meetings at the practice, for example, for victims of domestic abuse.
- GPs prescribed for patients with substance misuse problems in conjunction with the local substance misuse team. At the time of the inspection, the practice were providing ongoing care for eight patients to help stabilise and monitor their condition.
- The practice had recently undertaken a joint project with the local council to offer a free assessment of home heating for vulnerable patients, and consider how support could be provided to those who required it. This project recognised the impact that cold has on health for older people and children, and the impact upon an individual's mental health.
- The practice was a recognised 'safe haven' for people with a learning disability. This Derbyshire partnership scheme aimed to protect people with learning disabilities from potential bullying or abuse. It helped them feel safe and confident when out in the community by having access to a place where they could be supported if required.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

- The practice achieved 100% for mental health related indicators in QOF, which was 1.9% above the CCG and 7.2% above the national averages, with exception reporting rates generally in line with averages.
- 93% of patients with ongoing active mental health problems had received an annual health check during 2014-15.
- 88.4% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was 4.5% higher than local an national averages, although it was noted that the exception reporting rate was almost 10% above the averages for this indicator.
- The practice had completed 'Dementia Friends' training for all staff to improve their awareness of dementia and the support available to patients and their carers.
- A visiting psychiatrist provided appointments at the surgery each week for practice patients.
- A community psychiatrist nurse worked with the practice, and attended monthly multi-disciplinary meetings, to support patients experiencing poor mental health.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in January 2016. The results showed the practice was performing in line with, or above local and national averages. A total of 259 survey forms were distributed and 109 were returned, which was a 42% completion rate of those invited to participate.

- 93% 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%.
- 86% 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%.
- 100% of patients said the last appointment they got was convenient compared to a CCG average of 94% and a national average of 92%.
- 81% of patients described their experience of making an appointment as good compared to a CCG average of 77% and a national average of 73%.
- 85% of patients found the receptionists at this surgery helpful compared to a CCG average of 89% and a national average of 87%.
- 76% 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%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 48 comment cards and the vast majority of these were extremely positive about the standards of care received from the GPs and the nurses. Patients commented that they were treated with respect and were given sufficient time to discuss their health problems. Patients also said that the reception team were very helpful and courteous, and many noted the high standards of cleanliness within the practice. However, four cards included some negative feedback.

We spoke with thirteen patients during the inspection. All of the patients we spoke with said that they were treated with dignity and respect by all practice staff; that they were provided with sufficient consultation time; that scheduled appointments ran on time; and that the practice was always clean and tidy. The majority of the 13 patients reported satisfaction with the appointment system, and were provided with explanations on treatment options during consultations.

Some patients raised a concern with regards continuity in seeing the same GP, although there was an acknowledgement by most that they may have to wait longer to see a GP of their choice. The practice was aware of this issue and were in the process of appointing a new salaried GP. It was hoped that this may help to improve this situation, as well as create increased access to GP appointments generally.

The Brimington Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist 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 The Brimington Surgery

Brimington Surgery provides care to approximately 8,000 patients in the Brimington and Staveley areas within the borough of Chesterfield in North East Derbyshire. The surgery provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England, and services commissioned by North Derbyshire Clinical Commissioning Group (CCG). The practice operates from a modern purpose-built building.

The practice is run by a partnership of four part-time GPs (two males and two females). The practice employ two part-time salaried GPs (one male and one female), and presently have a vacancy for a further part-time salaried GP. This equates to five whole time GPs working within the practice at the time of the inspection. The practice use winter pressure funding provided by the CCG to contract an additional part-time locum GP to increase capacity to see patients during the winter periods.

The Brimington Surgery is an established training and teaching practice and accommodates GP registrars (a qualified doctor who is completing training to become a GP); foundation training (F2) doctors (a two-year postgraduate medical training programme for newly qualified doctors); and both medical and nursing students.

The practice employs three part-time practice nurses (all female), and has recently appointed a community practice nurse. The nursing team is complemented by a part-time health care assistant and a phlebotomist. The clinical team is supported by a practice manager and assistant practice manager a team of twelve administrative and reception staff. The practice partially funds a care co-ordinator post to provide additional hours to enhance care planning and co-ordination for their patients.

The registered practice population are predominantly of white British background. The practice is ranked as the fourth highest in the CCG in terms of the deprivation status of their registered patients (and the third highest for income deprivation in older people). The practice age profile has higher numbers of patients aged over 65 (practice value 21.5%, compared against a national average of 16.7%), and this is more pronounced for patients aged 85 and over.

The practice opens from 8am until 6.30pm Monday to Friday. Scheduled GP morning appointments times are available from 8.30am to 11.30am approximately, and afternoon surgeries run from 3pm to 5.30pm, apart from one Wednesday afternoon each month when the practice closes for staff training. Extended hours opening is available on either a Wednesday or Thursday evening from 6.30pm until 8.30pm.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed patients are directed to Derbyshire Health United (DHU) via the 111 service.

Detailed findings

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 12 April 2016 and during our inspection:

- We spoke with staff including GPs, the practice manager, the assistant practice manager, practice nurses and four members of the reception and administrative team. In addition, we spoke with representatives from three local care homes, the district nursing team, and two nurse specialists regarding their experience of working with the practice team. We also spoke with 13 patients who used the service, and two members of the practice patient participation group.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 48 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform either the lead GP for significant events, or the practice manager, of any incidents that occurred. A form was available to report incidents on the practice's computer system.
- The practice carried out an analysis of the significant events and reviewed these at clinical or staff meetings which were held each month.
- When there were unintended or unexpected safety incidents, people received support, truthful information, an apology, and were told about any actions taken to prevent the same thing happening again.

We reviewed incident forms for the ten significant events recorded by the practice team over the preceding 12 month period. This incorporated a range of incident types and included positive events to celebrate success. Learning points were identified to improve safety in the practice and actions were documented. For example, an urgent two-week referral (used for a suspected cancer diagnosis) was not made as there was no availability on the Choose and Book system (this is an electronic system which allows out-patient appointments to be booked at a preferred hospital at a convenient time and date), and a follow-up fax was not received by the hospital. This led to a delay of two months to subsequently book the patient's appointment. The practice applied learning from this event by implementing changes to their administrative protocols. Staff had to ensure compliance with the practice procedure that two week wait referrals were booked, typed, checked and sent on the same day, and an additional code was added to the patient record to enable a six weekly search to be carried out on the computer. This enabled the practice to be assured that all the referrals had been received and would be acted upon in a timely manner.

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

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices 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 requirements and policies were accessible to staff. The policies outlined who to contact for guidance if staff had concerns about an individual. There were lead GPs for safeguarding both children and adults, who had received training at the appropriate level (level 3) in support of these roles. Monthly child safeguarding meetings were held with the health visitor and midwife, which were well-documented and made available to other clinicians in the practice. Practice staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice in the reception and the consulting rooms advised patients a chaperone was available for intimate examinations, if required. Nursing staff would usually act as a chaperone, but some members of the reception and administration team were trained for this role, and could also provide this service. These staff wore a badge to identify them as a chaperone, and they had received a 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).
- We observed that the practice was tidy and maintained to high standards of cleanliness and hygiene. Two practice nurses shared the infection control clinical lead role and had undertaken specific training to support this aspect of their role. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken, most recently in June 2015, and we saw evidence that action was taken to address any improvements identified as a result. The practice contracted cleaning services to an external provider and

had developed specific cleaning schedules that were regularly monitored. The practice manager liaised with the cleaning contractor on a regular basis and systems were in place to quickly rectify any issues that arose.

- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Blank Prescription forms and pads were securely stored and there were systems in place to monitor their use. 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.
- We reviewed five staff files and found that recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.
- The practice had a safe system to manage incoming correspondence to ensure that any actions, such as a change to a patient's medicines, were completed promptly.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and there were risk assessments in place to monitor safety of the premises such as manual handling and the control of substances hazardous to health. The practice had conducted a fire risk assessment and carried out regular fire drills. Staff had received fire training, and some staff had attended training to act as fire marshals. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had some arrangements in place to control legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings), but had not received a formal risk assessment. However, the practice was able to provide evidence that they had organised this, and we saw evidence that this would be fully completed within one month of our inspection.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. We were provided with examples of how the whole team worked flexibly to ensure adequate cover was available at all times. Demand for GP appointments was closely monitored and if more capacity was required, locum GP sessions, or additional GP hours, were organised to address this. The practice only used locum GPs who had a history of working at the practice and therefore were familiar with systems and local procedures.

Arrangements to deal with emergencies and major incidents

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

- An audible alarm was in place, and there was an instant messaging system on the computers in all the consultation and treatment rooms and patient areas which alerted staff to any emergency.
- All staff had received annual basic life support training. We observed two incident reports in the last year where both a patient and a member of the public had collapsed at different times, and these demonstrated that the practice team were able to respond to emergency situations promptly and effectively.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. A copy of the plan was kept off site in case access to the premises was not possible. The plan was reviewed regularly with the most recent update in March 2016.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, and local guidance, for example, in relation to prescribing. The practice had systems in place to keep all clinical staff up to date when new guidance was received or updated, including a monthly clinical staff meeting. Minutes were recorded to ensure any clinician that had been unable to attend the meeting had access to the information.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available. However, the practice had relatively high overall exception reporting rates at 15.5%, compared to a local average of 11% and national average of 9.2%. The rates were higher in particular for indicators relating to heart failure, dementia, cardio-vascular disease and chronic obstructive pulmonary (lung) disease (COPD). Exception reporting is the removal of patients from QOF calculations where, for example, the patients had repeatedly failed to attend a review meeting or certain medicines could not be prescribed because of side effects. We reviewed practice data for 2015-16 (subject to external verification) and this demonstrated that the levels of exception reporting had decreased and were now more in line with expected averages (for example, the exception reporting rate for heart disease had decreased from 14.6% to 9.4% over a two year period). This exception reporting level remained high for COPD, and this was explained as being due potentially to a coding issue.

QOF data from 2014-15 showed:

- Prevalence rates for many long-term conditions were generally higher than local and national averages. For example, prevalence for diabetes was higher than local and national averages at 7.4% (1.78% above the CCG and 2.27% above the England averages). The practice provided their own data which highlighted more significant variances in these figures. This was related to the higher number of older patients registered at the practice, and due to the relatively higher levels of deprivation particularly affecting the older age group locally (the practice was ranked the third highest of 37 practices in the CCG in terms of elderly deprivation figures).
- Performance for diabetes related indicators at 100% was above the local and national averages of 96.7% and 89.2% respectively. However, exception reporting was higher in six of the ten relevant indicators including the measure of total cholesterol at 5mmol/l or less within the preceding 2 months. The practice exception reporting rate was recorded as 27.9% compared to the local average of 16.2%, and national average of 12%.
- Performance for mental health related indicators was higher than local and national averages at 100% (98.1% and 92.8% respectively). Exception reporting levels for these indicators were generally in line with local and national averages.

There was evidence of quality improvement including clinical audit.

- There had been nine clinical audits completed in the last two years, three of these were completed full cycle clinical audits where changes were implemented and monitored. One of the completed full cycle audits had produced positive outcomes for patients. This had reviewed the prescribing of broad-spectrum antibiotics as the surgery had been shown to be above local averages for prescribing rates. The initial audit in 2013 found that 50% of antibiotics were prescribed in accordance with local guidance against a standard of 80%. A review of patients and subsequent re-audit demonstrated compliance had improved to 78% in January 2015. A third audit in March 2016 showed that compliance had improved further to 90%, which was 10% higher than the recognised standard and below local and national prescribing rates for this medicine. Actions were implemented to ensure GP registrars, foundation GPs and locum GPs were more aware of the guidance to maintain this achievement.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure

prescribing was cost effective, and adhered to local guidance For example, to review medicines prescribed for patients with atrial fibrillation (an irregular heart beat).
- Findings were used by the practice to improve services. For example, a review of gynaecology referrals to secondary care had resulted in action that included referring appropriate patients to the continence clinic prior to referral to the gynaecologist.
- The practice participated in local benchmarking activities. For example, the practice undertook a quarterly review of data provided by their CCG including referral rates and hospital admissions.

Effective staffing

- The practice had developed induction programmes for all newly appointed staff. Specific induction programmes had been developed for nursing and administrative staff to assess and sign-off competencies in key tasks. For example, the practice nurse team leader had developed templates for clinical duties including venepuncture (taking blood) and administering childhood immunisations. The templates gave information on the task, and provided evidence that the newly appointed staff member had been observed in following the procedure in a competent and professional manner. Staff told us that when they started their roles, they were given time to shadow colleagues to gain a full understanding of their responsibilities, and were then provided with ongoing support until they felt confident with their duties.
- The practice ensured role-specific training with updates was undertaken for relevant staff e.g. for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- There was a commitment to staff development and a review of staffing requirements. For example, the senior nurse was in the process of completing an independent prescribing course. The practice had just appointed a community practice nurse to focus on patients previously managed by the community matron. This role enabled the practice to have more direction over the management of these patients in delivering co-ordinated and seamless care. The practice was funding the retiring community matron to mentor the new nurse to develop their role and share their expertise.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. Staff had received an appraisal within the last 12 months. We spoke to members of the team who informed us of how learning opportunities had been discussed during the appraisal and subsequently funded and supported by the practice, for example, a supervisory national vocational qualification (NVQ) for one of the team leaders.
- Staff received 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. A training matrix had been developed to collate details on the training status of the whole practice team, and systems had been developed to set prompts when update training was due. The practice had monthly protected learning time in which they either attended an event organised by their CCG, or arranged in-house training for the practice team.
- There was a robust support system in place for GP registrars, F2 doctors and medical and nursing students. GP registrar training events were shared with a local practice which also supported GP registrar placements. Nurses had access to supervision, and the nurse team leader had received second place in a national award for her role in mentoring nursing students at the practice. Monthly education meetings between the partners and practice manager facilitated the planning and co-ordination of training placements.

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.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services, or raising safeguarding concerns.
- The practice team worked collaboratively with other health and social care professionals to assess the range and complexity of patients' needs and plan ongoing care and treatment. Monthly meetings took place with representation from a wide range of professionals including specialist nurses (for example, the heart failure and respiratory nurses), the community psychiatric nurse, Careline (social care), the community learning

disabilities nurse, the district nurse, and the care co-ordinator. The GPs rotated their attendance at this meeting to ensure an inclusive approach. We observed one of these meetings taking place on the day of our inspection and noted the valuable discussions taking place between those in attendance. These meetings were documented with any agreed actions being recorded.

- Bi-monthly palliative care meetings were held between the practice team and the district nurse, Macmillan nurse and care co-ordinator to review those patients on the practice's palliative care register. This meeting included a discussion of any new cancer diagnoses, and a review of any deaths to consider any learning points.
- The practice worked with the CCG's medicines management team who attended the practice each week.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Staff were able to articulate how this applied in individual cases, and the actions they would take to adhere to the guidance correctly.
- Where a patient's mental capacity to consent to care or treatment was unclear, the clinician assessed the patient's capacity and, recorded the outcome of the assessment. Care home staff informed us how GPs had contributed towards best interest assessments for their residents. For example, a GP was due to meet with an independent advocate about a patient with learning disabilities to discuss further investigation and treatment options.
- Consent forms were completed for any invasive procedures including coil fittings and minor surgical procedures.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- A health trainer was available each week to provide advice on healthier lifestyles, including diet, alcohol consumption, and social issues including debt management and isolation. The health trainer was able to signpost patients into ongoing community based support programmes including services to help patients stop smoking.

The practice's uptake for the cervical screening programme was 78.6%, which was in line with the local CCG average of 79.4%.There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening and uptake was in line with local and national averages.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95.9% to 100% (local average 95.2% to 98.9%) and five year olds from 97.4% to 100% (local average 96.5% to 99.1%).

The practice provided health checks for new patients and NHS health checks for patients aged 40–74. A total of 47.3% of patients offered this assessment in the last 12 months had attended the practice to receive this check. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

- Disposable curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations and treatments.
- Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.
- If patients wanted to discuss sensitive issues, or appeared distressed, they were offered a private room next to the reception to discuss their needs.

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

- 91% of patients said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 84% of patients said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern which was the same as the CCG average of 91%, and above the national average of 85%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern in line with the CCG average of 93% and national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Brimington Surgery was the first GP practice in the locality to receive the Derbyshire Dignity Campaign Award in February 2016, an initiative developed by the local County Council and CCG. This reflected the passion and commitment within the practice team to provide high quality care to their patients. The practice displayed posters highlighting the award with a ten point plan for staff to adhere to at all times. The practice were proud of this achievement and ensured this was maintained by reviewing one of the ten points in turn at each monthly staff meetings to review what they were doing, and agree what might be done to continually enhance their achievements. Staff wore badges to inform patients that they the practice had received the two year dignity accreditation.

Care and nursing home staff informed us that each home had a named GP for continuity. They said that residents were treated as individuals and their needs were accounted for. For example, the GP was involved in keeping patients' care plans updated and involved care home staff and patients' families in decisions where that person was not able to make an informed decision for themselves. We also spoke with specialist nurses and a member of the district nursing team who reported that the GPs and the whole practice team were patient-centred, and always did their best for their patients. All the community based staff we spoke with stated that the GPs were approachable, accessible and respectful of their opinions.

The practice worked with their PPG to raised funds for local charities, including the Macmillan nursing service. This included coffee mornings, cake stalls at the village fair and book sales. The practice participated in a national project to produce 'twiddlemuffs', a visual and tactile stimulation for patients with dementia who benefited from having something to keep their hands occupied. The scheme helped foster a community spirit by inviting patients to help produce them, or to provide unwanted supplies of wool.

The partners and managers cared for their employees and some staff gave examples of how they had been supported during difficult personal circumstances. A stained-glass memorial window had been placed in the reception area in memory of a valued member of the practice team who had died.

Care planning and involvement in decisions about care and treatment

Outstanding ☆

Are services caring?

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. A caring and patient centred attitude was demonstrated by all staff we spoke with during the inspection.

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

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

Patient and carer support to cope emotionally with care and treatment

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

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 1.38% of the practice list as carers, and identified new carers upon registration. Written information was available to direct carers to the support services available to them. Links had been established with the Derbyshire Carers Association who had recently held a promotion event in the practice reception, and this led to the identification of six new carers. The practice had recently appointed a member of the team to become the 'Carers' Champion' to further develop the identification and support of carers.

The practice worked to recognised high quality standards for end of life care and had written care plans in place to ensure that patient wishes were clear, and that they were involved in the planning of their own care. The practice reviewed patient deaths to ensure that optimal care had been delivered and to consider any learning. A recent audit demonstrated that 80% of patients had died in their preferred place and 69% of patients had access to anticipatory medicines (specific medicines to help control symptoms) if required. The practice team sent a card to relatives who had experienced a bereavement to offer condolences, and support, including signposting to appropriate services such as counselling, was available if required.

A 'Village Friends Group' had been established for practice patients by the community matron, with support from the practice, to support those who were bereaved. This grew and expanded to include patients who were socially isolated and also to include patients from other local GP practices. Activities including lunch clubs and theatre trips took place which provided an opportunity for social interaction and promoted a strong sense of local community. The group became independent and ran without ongoing support from the practice, although the practice still refers patients into this group and promote it within the surgery

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, it had identified gaps in services and raised these with their CCG from a commissioning perspective. This included a proposal to provide an ear irrigation service for patients in the locality. Whilst this was not supported due to the limited availability of supporting data, it demonstrated the practice's willingness to develop local services for their own and other patients.
- The waiting area contained a wide range of information on services and support groups. There was a community noticeboard promoting local support groups, healthcare clubs and healthy activities.
- A touchscreen check-in facility was available and a TV screen displayed information on health, local services, and appointments. The practice provided some higher chairs for patients who had difficulty in standing from a low seat. A second waiting area was available on the first floor for patients being seen upstairs.
- The layout of reception made it difficult to maintain confidentiality at times. However, the practice used a radio to help with this, and displayed a notice asking patients to stand back from the person at the desk. A separate room was available next to reception which was used for private and sensitive discussions.
- The practice provided joint injections, and would undertake these in the patient's home if necessary. For example, when the patient may have had restricted mobility due to severe osteoarthritis.
- The practice hosted a number of externally managed services on site to facilitate better access for patients. This included weekly consultant psychiatrist clinics; physiotherapy; the Citizens Advice Bureau; substance misuse surgeries; and podiatry assessments for patients with diabetes. The practice welcomed other professionals to use their rooms to see individual patients in a familiar environment – for example, patients with an eating disorder.
- There were longer appointments available for patients who required them. Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Same day appointments were available for children and those patients with medical problems that required to be seen urgently.
- Long-term condition reviews were co-ordinated to ensure that patients with more than one condition could be reviewed as part of one appointment.
- The practice provided care for more than one hundred residents across four local care and residential homes. We spoke to staff in three of these homes who informed us that the practice was highly responsive to their patients' needs. Urgent visits were done on the day as required and planned 'ward round' visits ensured patients were kept under regular review.
- The practice provided services for vulnerable patients including a local unit which provided accommodation for people with a history of drug and alcohol dependency, mental health difficulties, and ex-offenders. As this group did not regularly engage with health services, the practice saw these patients although they may not have made an appointment in recognition that this was an opportunity to provide them with essential care or support. The practice supported homeless people to register with the practice.
- The premises provided good accessibility for patients in wheelchairs, or those with limited mobility. A disabled toilet was available. Most services were accessed on the ground floor, but a lift was available for any patients needing to go up to the first floor. A hearing loop and available, and the practice communicated with some patients by text or fax if they had hearing impairments. Signing interpreters were used if required as part of a consultation.
- Translation services were available for patients whose first language was not English. Staff had print-outs available to help identify languages when it was not easy to communicate.
- A suggestion box was available for patients to make comments about the practice.
- A large notice board displayed staff photographs, including their names and roles to help inform patients about the practice team.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice had produced a newsletter for patients providing useful information about the practice and general advice. Although the last issue had been in spring 2015, the practice was in the process of finalising the latest edition.
- There was designated notice board for the PPG displaying the latest annual report and details of the next meeting. However, there was limited information displayed about their activities and achievements, or the feedback received from patients. Minutes of PPG meetings were available on the practice website.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. The practice closed on one Wednesday afternoon each month for staff training.

GP appointments were available from 8.30am to 11.30am every morning, with additional appointments being provided at the end of the scheduled clinics to accommodate those patients with urgent needs. Afternoon GP appointments were usually available between 3pm to 5.30pm. The practice offered an extended hours' clinic on either a Wednesday or Thursday evening from 6.30pm to 8.30pm for working patients who could not attend during normal opening hours.

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

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

- 93% of patients said they could get through easily to the practice by phone compared to the CCG average of 77% and national average of 73%.
- 71% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.

On the day of our inspection, we saw that the next available routine GP appointment was available in two days. Staff told us this was usually the case, although it did extend beyond this sometimes. However, the situation was closely monitored by the practice management and additional GP capacity was organised to address this as required. During the winter months the practice used regular locum GPs to increase GP access when the pressure for appointments was at its greatest. Patients we spoke with on the day said they were usually able to get appointments when they needed them, but acknowledged they may need to wait longer to see a specific GP of their choice.

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 responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the waiting area and on the practice website.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints, and action was taken to as a result to improve the quality of care. For example, a complaint had arisen regarding the perceived negative attitude of a clinician during a consultation. This was investigated by the practice, and a meeting was subsequently held with the complainant to provide an apology and to inform them of the learning they had applied from this incident.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The practice had developed clear practice values and staff understood these values. The values included a focus on patient dignity and patient involvement.
- The practice held a quarterly business planning meeting between the partners and practice management. This reviewed key issues including the premises, finance, and staff including succession planning. In addition, fortnightly partners' meetings were held and documented, to ensure effective an oversight of management issues and regular discussion.
- The partners planned for future developments and had engaged with their CCG and other local practices to consider the potential for federated working arrangements.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. All GP partners had designated managerial and clinical lead areas of responsibility.
- Practice specific policies were implemented and were available to all staff electronically. The practices had recently introduced an electronic system which collated information including training records and logs of medicine checks. This was evolving and was eventually planned to incorporate all documents including policies to ensure easy access to information for all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of clinical audit and benchmarking against other local practices was used to monitor quality and to make improvements. The practice engaged with their CCG, and the practice attended locality meetings and the practice managers' forum to work collaboratively and share best practice.
- Arrangements were in place for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners and practice management demonstrated they had the experience, capacity and capability to run the practice effectively and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

One of the GP partners was awarded the Fellowship of the Royal College of General Practitioners (FRCGP) in 2015 in recognition of his contribution to quality improvement and education in general practice.

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

- Staff told us the practice held monthly full practice team meetings. These had recently been reviewed to include all staff members, whereas previously representatives had attended the meeting and fed back to colleagues in their section. The practice also held clinical meetings for the GPs, nurses and practice management on a monthly basis. Additionally, monthly education meetings took place to primarily review the planning and co-ordination of the placements for GP registrar, foundation training doctors and medical students.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Team away days had been held annually for the last ten years. Staff told us that they enjoyed these events and that they provided an excellent opportunity for team building. Additional social events throughout the year, added to the sense of a strong and supportive team spirit within the practice.
- Staff said they felt respected, valued and supported, by the partners and managers in the practice.

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

Are services well-led?

Good

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

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 participation group (PPG) involvement at events such as the annual flu vaccination programme; through patient surveys; via complaints received; from feedback received on the NHS Choices website; comments made via the suggestion box in the waiting area; and responses received as part of the Families and Friends Test (a simple feedback card introduced in 2013 to assess how satisfied patients are with the care they received).
- In recognition of the number of patient surveys being undertaken, the practice decided not to undertake their own internal patient survey last year. Instead, they focused upon the nursing and residential homes to assess their satisfaction with the service delivered by the practice. The results were extremely positive, although the practice used this to review what they could do better and developed an action plan as a positive outcome. For example, an action was to audit hospital admissions for nursing and care home patients to consider any learning points.
- The PPG met quarterly, and had a core membership of approximately 15 with an extended virtual network of over 80 people which communicated via e-mail. The PPG were aware that they were predominantly in the middle to older age group although significant efforts had been used to encourage wider representation. For example, by linking with schools and the local care home for clients with a learning disability, and varying times to suit those at work or at home by alternating between lunch time and evening meetings. The PPG had been instrumental in influencing several developments at the practice. For example, the practice extended its advance GP appointment booking from seven days ahead to four weeks as the PPG suggested that patients would be prepared to wait longer to book with a preferred GP. This change proved to be popular with patients.
- 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.
- The practice acknowledged their role in supporting their local community, and they told us how this was an important aspect of their work. For example, the practice manager attended parish council meetings; the practice had worked with their community matron to establish the 'Village Friends Group'; and the practice participated in local events such as the village fair.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice was a pilot site for community matrons, and were at the forefront of instigating their own multi-disciplinary meetings to improve the safety, quality and co-ordination of care for patients.

The practice had reviewed the needs for complex patients with the retirement of their community matron, and decided to appoint their own community practice nurse. This role offered opportunities for the practice to shape and develop this role to meet their own specific requirements as a direct employee of the practice.