Swadlincote Surgery

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
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 Swadlincote Surgery on 7 September 2016. Overall the practice is rated as outstanding.

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

- Most staff understood and fulfilled their responsibilities to raise concerns and report incidents
- The practice used alternative methods to improve patient outcomes, For example; they had recruited a physician's associate and an advanced nurse to provide additional clinical support for routine and urgent needs.
- Feedback from patients about their care was consistently positive.
- The practice had corroborated with another practice within their locality to plan how to manage winter pressures and share resources.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice were striving to achieve dementia friendly status by completing training for all non-clinical staff and PPG members, and had implementing dementia friendly signage,
- The practice had implemented a lead GP to provide monthly ward rounds at the care homes aligned to them

Summary of findings

- The practice had strong and visible clinical and managerial leadership and effective governance arrangements

We saw areas of outstanding practice:

- The practice worked closely with the multi-disciplinary team which enabled 90% of patients on the practice's palliative care register to die in their preferred place of death.
- The practice had researched the needs of their population and had adjusted the skill mix of their staff so they were able to provide alternative ways of providing clinical care. They recruited a physician's associate who was able to work alongside GPs to assess and treat patients. This had reduced the waiting time for routine appointments by two days. They had enabled two healthcare assistants (HCA) to develop clinical skills to NVQ level 3 and provide specialist clinical care including wound care, phlebotomy and basic chronic disease assessments with appropriate oversight and mentoring from a clinician. They had also funded a post graduate course for a practice nurse in advanced practice to enable chronic disease management and urgent care to be provided in the practice. This reduced the workload for GPs and improved access to care for patients seeking urgent care and had reduced waiting time for patients with a chronic illness by three days.

We found one area where the practice should take steps to make improvement;

- The practice should ensure that all staff fully understand what a significant event is and enable staff to record and report all events that are significant, including events that they may not think are serious in nature.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was a system in place for reporting and recording significant events. Most staff knew how to report incidents but this needed strengthening.
- Lessons were shared to make sure action was taken to improve safety in the practice. Detailed records included analysis of the events and risk assessment to reduce potential reoccurrence. Learning outcomes were shared in practice meetings and they held an annual review to check changes had been embedded.
- When there were unintended or unexpected safety incidents, patients received support, information, and an apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. Staff were appropriately trained.
- There were effective systems in place to ensure safe management of infection control procedures, management of medicines, and staff recruitment procedures
- Risks to patients were assessed and well managed. This included health and safety, ensuring sufficient staff in place to meet patient needs, management of test results and suitable emergency procedures if a patient presented with an urgent medical condition.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

- There were systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines, and clinicians used these as part of their work.
- Audits were considered an important activity to drive improvement and were undertaken over two cycles. Improvements were made as a result to enhance patient care. Registrars were encouraged to conduct audits as part of their personal development
- Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further

training needs had been identified through the appraisal process and training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff and that development was driven by individual need.

- The practice was a training practice that embraced opportunities to develop staff and had enabled two healthcare assistants (HCA) to develop clinical skills to NVQ level 3 and provide specialist clinical care including wound care, phlebotomy and basic chronic disease assessments with appropriate oversight and mentoring from a clinician. They had also funded a post graduate course for a practice nurse in advanced practice to enable chronic disease management and urgent care to be provided in the practice. This reduced the workload for GPs and improved access to care for patients seeking urgent care. This had resulted in waiting time being reduced for patients with a chronic illness from 10 days to seven days in the preceding six months.
- Staff worked closely with multi-disciplinary teams to plan, monitor and deliver appropriate care for patients. The teams included midwives, health visitors, district nurses, social care team and the mental health team. Care plans and records were shared where required so that all the information needed for patients' ongoing care could be accessed in a timely way and in line with relevant protocols. The practice had provided additional training for staff, including attached staff in palliative care.
- Staff worked with, and had a high level of engagement with other health care professionals to understand and meet the range and complexity of patients' needs.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. The practice had achieved 97% of the total points available. Practice supplied data that demonstrated that they were performing well with an exception reporting rate that was lower than CCG and national averages. (This data had not been verified or published at the time of our inspection).

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for some aspects of care. Feedback from patients about their care and treatment was

positive. For example; 91% of patients said the GP was good at listening to them and 90% of patients said the GP gave them enough time. This was comparable with CCG and national averages.

- We observed a strong patient-centred culture. Patients told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about some of the services available was easy to understand and accessible throughout the three reception areas. We saw staff treated patients with kindness and respect, ensuring that confidentiality was maintained. Staff told us that they worked hard to provide for patients' needs and we saw evidence of this when a receptionist assisted a wheelchair user.
- The practice had provided training modules for staff from the multi-disciplinary team as well as practice staff. A total of 90% of patients on the practice's palliative care register died in their preferred place of death, with 10% dying in hospital or a hospice.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

They were aware of the practice population and responded to the specific needs of its community by providing extra support to patients where required

- They had engaged with another practice in the locality to work on a project to plan for managing the winter pressures by sharing resources.
- They utilised the services of a Well-being Worker who was able to assist with referrals to the Live Life Better Derbyshire scheme. The scheme provided support for people with specific needs, including people who were carers or required help with exercise or activity, weight management, smoking cessation and help with issues such as debt and housing.
- They were proactive in increasing access to clinical appointments by recruiting a Physicians Associate to assess and treat patients. This had reduced waiting time for routine appointments by two days.
- They had recruited an advanced nurse (due to start in October 2016) to assess patients with a routine and urgent needs.
- They had trained a nurse practitioner to post graduate level to provide chronic disease management and triage. This had already had the impact of reducing the waiting time for some appointments from 10 days to seven days and enabled GPs to see patients with more complex needs.

Summary of findings

- They mentored a community pharmacist who worked with the practice to review medicines and was working towards an independent prescriber qualification.
- Routine appointments could be booked on line, by telephone or by calling at the surgery. We saw that the next available routine appointment to see GP was in six days. Patients told us that urgent appointments were usually available the same day. Telephone consultations and home visits were available by appointment and where required.
- The practice hosted a school visit for year 5 and 6 pupils from a local primary school in order to engage with young people and promote healthy lifestyle and choice. Three GPs also attend local schools to provide educational sessions on a variety of health subjects.
- The practice carried out advance care planning for patients with dementia and was striving to achieve "dementia friendly" status at the practice. They had installed dementia friendly signage within the practice.

Are services well-led?

Outstanding 

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

- They have configured their services to meet their demographic, have put in place improvements where performance was lower and are actively looking to improve patient experience
- There was a clear vision and strategy with quality and safety as its top priority. This was shared with staff who were clear about their responsibilities in relation to this. For example; implementing new approaches to providing clinical care through utilisation of two new roles, the physicians associate, and an advanced nurse role.
- There was a clear leadership structure and staff felt supported by management. High standards were promoted and owned by all practice staff and teams worked together across all roles. Staff were actively recruited, developed and trained to extend both their own knowledge and also their skills to improve the delivery of care and the service to patients. They had also funded a post graduate course for a practice nurse in advanced practice to enable chronic disease management and urgent care to be provided in the practice. This reduced the workload for GPs and improved access to care for patients seeking urgent care and had reduced waiting time for patients with a chronic illness by three days.

Summary of findings

- The practice had an effective approach to governance and all staff were aware of their role in contributing to good governance. Practice meetings included a standing agenda that ensured key governance areas were discussed and staff felt able to contribute.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice was proactive in seeking opportunities to improve practice and the quality of care for patients. For example; working with other practices within the locality to manage winter pressures.
- The practice gathered feedback from patients using a variety of methods and it had a very engaged patient participation group which influenced practice development; for example implementation of a triage system to improve access to clinical advice and appointments.
- There was a strong focus on continuous learning and improvement at all levels, and a drive to enable staff to develop new skills that would increase the skills mix and assist the practice to provide enhanced care to patients.
- Patient participation was encouraged and the practice had a virtual patient participation group with over 650 members.

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

Outstanding ☆

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

The prevalence of patients aged over 65 at the practice was around 3% higher than the CCG and England average and the practice had adjusted its services to meet these needs For example;

- They utilised the services of the community team and a care coordinator to help provide proactive, personalised care to meet the needs of the older people in its population, and those patients who were at risk of unplanned admission to hospital. Care plans were shared where relevant to ensure timely access to care for people who are cared for by different teams and services.
- All patients were contacted following hospital admission to help identify any additional support that may be needed
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had 11 care homes aligned to them and the lead GP visited each month to conduct a ward round. A recent survey commissioned by Southern Derbyshire CCG was very positive about the relationships with the surgery and the care that patients received.
- The practice had access to a falls prevention service that identified people who were at risk of falling. When a notification was received, the GP conducted a medicines review and assessed the risk of fractures. Patients are also discussed at multi-disciplinary team (MDT) meetings with care coordinator and referrals made via a single point of access for physiotherapy, occupational therapy and other services.
- The practice worked closely with the community matron to ensure that patients received the highest standards of care.
- They worked with community pharmacist to ensure that prescribing was appropriate. There was a delivery service for housebound and older patients.
- They were proactive in increasing access to clinical appointments by recruiting a physicians associate to assess and treat patients. This had reduced waiting time for routine appointments by two days.

Summary of findings

People with long term conditions

Outstanding 

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

- Nursing staff had lead roles in chronic disease management and were able to prescribe medicines. They worked closely with the GP QOF leads
- Patients at risk of hospital admission were identified as a priority.
- A total of 72% of patients with diabetes had achieved a blood sugar level of less than 64 mmol in the preceding year, which was slightly lower than CCG and national averages which were 79% and 77% respectively. The practice had recognised their under achievement and had recruited and trained two additional practice nurses to provide chronic disease management. This had resulted in the practice achieving a total of 100% for diabetes related indicators and 100% for COPD related indicators for the QOF performance year 2015/16. (this data was supplied by the practice and has not yet been verified or published)
- They had trained a nurse practitioner to post graduate level to provide chronic disease management and triage. This had already had the impact of reducing the waiting time for appointments from 10 days to 7 days and enabled GPs to see patients with more complex needs.
- They had trained a Health care Assistant (HCA) to provide basic assessment for people with a chronic illness and this initial review contributed to patient's overall health check which reduced the amount of time required with a qualified nurse for some patients.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- They were proactive in increasing access to clinical appointments by recruiting a Physicians Associate to assess and treat patients. This had reduced waiting time for routine appointments by two days. Longer appointments and home visits were available when needed.
- The practice had GP QoF leads for all disease areas
- The practice had employed a dedicated data quality clerk with responsibility to implement a recall system for patients with long term conditions. This resulted in higher than average exception coding in some areas during 2015. However, following a review of patients on an individual basis, the

practice supplied data to show 100% achievement for QoF in 2015/16 with exception coding which was in line with CCG and national averages. This data had not yet been verified and published.

- Influenza clinics were provided in extended hours, routine hours and were also offered to patients opportunistically. These were also provided during home visits and care home ward rounds.
- The practice held a number of development sessions with the PPG including dementia and palliative care as health related subjects.

Families, children and young people

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses who were hosted on the premises. Meetings are held every 4 weeks with the team and safeguarding lead GP to discuss patients and concerns.
- There was a triage system for on the day patient access to effectively manage patient demand in a way which was safe and responsive to needs. This enabled patients to be prioritised in a clinically appropriate way and seen by the most appropriate clinician.
- They were proactive in increasing access to clinical appointments by recruiting a Physicians Associate to assess and treat patients. This had reduced waiting time for routine appointments by two days.
- The practice offered 30 minute appointments for 6 week baby checks. This recall was completed by one of the patient coordinators and all failures to attend were followed up.

Summary of findings

- The practice hosted a school visit for year 5 and 6 pupils from a local primary school in order to engage with young people and promote healthy lifestyle and choice. Three GPs also attend local schools to provide educational sessions on a variety of health subjects.

Working age people (including those recently retired and students)

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- A total of 96% of eligible women had received a cervical smear test within the preceding five years which was significantly higher than the CCG and national averages which were 84% and 82% respectively. There was a dedicated data quality clerk and a recall system. Any failure to attend was reported to the safeguarding administration lead.
- The practice provided phlebotomy and chronic disease reviews from 7.00am Monday to Friday.
- The practice booked patients around their working hours if it was clinically appropriate to do so.
- Routine telephone appointments with GPs and nurses were available for patients who found it difficult to get to the practice.They had recruited an Advanced Clinical Practitioner (due to start in October 2016) to assess patients with a routine and urgent needs.
- They were proactive in increasing access to clinical appointments by recruiting a Physicians Associate to assess and treat patients. This had reduced waiting time for routine appointments by two days.
- GPs and Practice nurses held clinics until to 6.30pm
- The practice encouraged an out of area registration scheme which supported people commuting to the area for work. There were 98 patients registered since November 2015.
- Online access was available for repeat prescriptions, appointment booking and detailed coded record. The practice's uptake was 22.5% which was in the top third of all practices in the locality.

Summary of findings

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There were two care homes for adults with severe disabilities aligned to the practice. There was a dedicated GP lead and nurse practitioner trained to carry out learning disabilities health checks in extended appointments. The lead GP worked very closely with the community lead for learning disabilities. The practice had completed 50 health checks during the current year and had the remaining 36 planned up until march 2017. The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients and informed vulnerable patients about how to access various support groups and voluntary organisations.
- They were proactive in increasing access to clinical appointments by recruiting a physicians associate to assess and treat patients. This had reduced waiting time for routine appointments by two days.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice developed an additional support board in the reception area assist patients who needed extra help in navigating health care systems and who were vulnerable but may not be on any other register. For example, patients who had an alcohol dependency dependent and homeless people.
- All staff are aware of the individuals who were in need of additional support.
- The practice routinely shared information with other healthcare professionals and agencies unless there was a specific reason not to.
- The safeguarding lead was an experienced GP lead and was supported by a patientservices manager
- All new cancer diagnoses were reviewed every 6 weeks in an end of life meeting that included relevant members of the MDT.
- The practice had strong local links with the voluntary sector and included representatives in locality meetings
- They hosted a well-being worker in the practice for GPs and patient self-referral to the 'Live Life Better Derbyshire' programme.

Summary of findings

- All staff, including receptionists were able to refer patients to the care coordinator and would actively do this where concerns were identified.

People experiencing poor mental health (including people with dementia)

Good

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

- A total of 88% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG and national averages which was 85% and 84% respectively. They had achieved this with an exception reporting rate of 4% which was significantly better than CCG and national averages.
- A total of 95% of patients with a serious mental health condition had had their alcohol consumption recorded in their record within the preceding year. This was comparable with the CCG and national averages which were 92% and 90% respectively. The exception reporting rate was also similar to CCG and national averages.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia and was striving to achieve “dementia friendly” status at the practice
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice held a training session provided by an external trainer for the patient participation group. Dementia friendly signage was installed in the practice public areas.
- The practice recently hosted a counsellor in practice to address the long waiting list for patients waiting to access counselling services.
- The practice referred patients to a local memory clinic for support.

Summary of findings

- Longer appointments with GPs were offered to patients with mental health issues which were usually 20 minutes. Continuity of care was encouraged for this group of patients and facilitated wherever possible.
- They were proactive in increasing access to clinical appointments by recruiting a Physicians Associate to assess and treat patients. This had reduced waiting time for routine appointments by two days

Summary of findings

What people who use the service say

The national GP patient survey results were published in 2016. The results showed the practice was performing in line with local and national averages. 220 survey forms were distributed and 118 were returned. This represented a 54% response rate

- 57% of patients found it easy to get through to this practice by phone compared to the CCG average of 72% and the national average of 73%.
- 84% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 85% and the national average of 76%.
- 84% of patients described the overall experience of this GP practice as good compared to the CCG average of 87% and the national average of 85%.
- 75% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 78% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 14 comment cards which were all positive about the standard of care received. Patients commented on the excellent service they had received and that the GPs were professional and kind.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service SHOULD take to improve

We found one area where the practice should take steps to make improvement;

- The practice should ensure that all staff fully understand what a significant event is and enable staff to record and report all events that are significant, including events that they may not think are serious in nature.

Outstanding practice

We saw several area of outstanding practice:

- The practice worked closely with the multi-disciplinary team which enabled 90% of patients on the practice's palliative care register to die in their preferred place of death.
- The practice had researched the needs of their population and had adjusted the skill mix of their staff so they were able to provide alternative ways of providing clinical care. They recruited a physician's associate who was able to work alongside GPs to assess and treat patients. This had reduced the waiting time for routine appointments by two days. They had enabled two healthcare assistants (HCA) to develop clinical skills to NVQ level 3 and provide specialist clinical care including wound care, phlebotomy and basic chronic disease assessments with appropriate oversight and mentoring from a clinician.
- They had also funded a post graduate course for a practice nurse in advanced practice to enable chronic disease management and urgent care to be provided in the practice. This reduced the workload for GPs and improved access to care for patients seeking urgent care and had reduced waiting time for patients with a chronic illness by three days.

Swadlincote Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and an Expert by Experience.

Background to Swadlincote Surgery

Swadlincote surgery provides primary medical services to 13,589 patients through a General Medical Services (GMS) contract. Services are provided to patients from a single site which occupies purpose built premises in Swadlincote.

The practice is run by a partnership between eight GPs (six male and two female) The practice is a training practice for undergraduate medical students and GP registrars and has a physicians associate.

The practice has three nurse practitioners, two part-time practice nurses and two part-time health care assistants. An advanced nurse has been recruited and is due to start at the practice in October 2016.The clinical team is supported by a full-time practice manager and assistant practice manager and a team of administrative, secretarial and reception staff.

The community nursing team visit the practice regularly and work closely with the practice team.

The registered practice population are predominantly of white British background, and are ranked in the sixth least deprived decile and income deprivation which is slightly lower than the national average. The practice has an age profile which is significantly higher for people over 65 years.

The practice is open from 8am to 6.30pm on Monday to Friday. The consultation times for morning GP appointments start at 8.30am to 12pm and afternoon appointments are offered from 3pm until 5.30pm. There are extended hours offered from 7am for some services and the practice sees additional patients at the end of the clinic session until 6.30pm if necessary. Home visits and telephone consultations are provided throughout the day.

The practice has opted out of providing out-of-hours services to its own patients. This service is provided by Derbyshire Health United through the 111 system.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 September 2016. During our visit we:

- Spoke with a range of staff (insert job roles of staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members

Detailed findings

- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

· Is it safe?

· Is it effective?

· Is it caring?

· Is it responsive to people's needs?

· Is it well-led?

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

· Older people

· People with long-term conditions

· Families, children and young people

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

· People whose circumstances may make them vulnerable

· People experiencing poor mental health (including people with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

The practice had systems and processes in place to enable staff to report and record incidents and significant events effectively.

- Staff told us they would inform the practice manager or assistant practice manager of any incidents. There was a recording template available on the practice's computer system and staff knew where to find this and how to record an event. However, some non clinical staff we spoke with had limited knowledge of what constituted a significant event and generally considered them to be of a serious nature which could potentially lead to under-reporting. This could mean that the practice does not learn from some less serious or good events.
- The practice carried out a thorough analysis of significant events annually and discussed them as a regular agenda item at monthly meetings with GPs, clinical staff and other staff, and at other meetings with all other staff groups.
- There had been 14 significant events recorded in the preceding 12 months and these had been appropriately reviewed and learning shared with practice and any other relevant staff. Records showed that where there were unintended or unexpected safety incidents, patients were offered support, information about what had happened and apologies where appropriate.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We found that there was an effective process to act on safety alerts and that staff understood what to do and recorded their actions. We looked at recent safety alerts and found that these had been acted upon. The practice told us alerts were discussed at practice meetings as a standing agenda item. We saw evidence of all the recent Medicines and Healthcare products Regulatory Agency (MHRA) alerts recorded in a spreadsheet for further discussion and any appropriate action was taken to ensure patient safety.

Overview of safety systems and processes

- We saw the practice had effective systems, processes and practices in place to keep patients safe and safeguarded from abuse. These included arrangements to safeguard children and vulnerable adults from abuse which were in line with local requirements and national legislation. There was a lead GP responsible for safeguarding within the practice and staff were aware of who this was. The practice had policies and procedures in place to support staff to fulfil their roles and staff knew who to contact for further guidance if they had concerns about patient welfare. Staff had received training relevant to their role. GPs were trained to the appropriate level to manage child safeguarding (Level 3) and nurses were trained to manage child safeguarding at level two. Staff we spoke with were able to give examples of action they had taken, or would take in response to concerns they had regarding patient welfare. The practice held a monthly safeguarding meeting which was attended by the lead GP, school nurse, health visitor and the safeguarding administrator. We saw evidence of a recent meeting held in June 2016 where meeting minutes showed that each safeguarding section was addressed. For example; relating to 'children in receipt of active care and protection'; 'children in need of safeguarding'; and 'looked after children.' The meetings minutes were consistent over time demonstrating a safe track record over the long term.
- A poster was displayed in the waiting area which advised patients that chaperones were available if required. The nurses and some reception staff acted as chaperones and were trained for the role and had received a Disclosure and Barring Service 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).
- The practice had arrangements in place to ensure appropriate standards of cleanliness and hygiene were maintained. There was a nurse practitioner who was the infection prevention and control (IPC) lead. We saw that current staff had completed mandatory infection control training. Regular infection control audits were undertaken, the most recent audit being in July 2016. Actions required were recorded and marked as completed. Changes had been implemented, and we saw evidence that action had been completed. For example; clinical waste bins had been replaced, fabric seats had been changed in the waiting area, and the cleaning team had added carpet cleaning to their deep clean schedule. The infection control lead was

enthusiastic about making improvements and was involved in training for newly recruited staff; had included infection prevention and control as an agenda item at clinical meetings; and conducted regular handwashing audits in the practice.

- Arrangements for managing medicines, including vaccinations and emergency medicines ensured that patients were kept safe. For example, there was a temperature monitoring system in the medicines fridges and staff knew what to do in the event of a vaccine fridge failure. There was a stock rotation system for medicines and emergency medicines were checked regularly and records kept of this.
- Regular prescribing audits were undertaken with the support of the CCG medicines management team (MMT) to ensure prescribing was in line with best practice guidelines for safe prescribing. There was a system in place for monitoring patients taking high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We saw evidence of monitoring of high risk medicines according to the shared protocols and there was a protocol where the lead GP (or his appointed doctor) was the only clinician authorised to sign off the prescription. All high risk medicines were read coded in patients' records so that these could be easily monitored and audited.
- The practice had a process to review and cascade medicines alerts received via the Medicines and Healthcare Regulatory products Agency (MHRA). When this raised concerns about specific medicines, searches were undertaken by the GPs and practice pharmacist to check individual patients and ensure effective action were taken to ensure they were safe. For example, prescribing an alternative medicine if a concern had been raised about the safety of a particular medicine.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. A log-in book was used to track the serial number of prescription pads on delivery and when they were distributed through the practice.
- 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 personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and staff we spoke with were able to identify potential health and safety concerns. The practice had up to date fire risk assessments which were conducted by an external company and carried out regular fire drills. We saw records to show that 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 a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).These were comprehensive and regularly reviewed.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents and staff knew how to respond to an emergency.

· There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

· All staff received annual basic life support training and there were 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. There was a system and process for checking emergency equipment and we saw records to show that this was followed.

Good

Are services safe?

· The practice had a defibrillator available on the premises and oxygen with adult and children's masks which were checked and found to be in date and fit for use.

· The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this was also available offsite.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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 97% of the total number of points available. Overall exception reporting rate was 9% which was 2% lower than the CCG average and the same as the National average.(Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

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

· Performance for diabetes related indicators was similar to CCG and national averages. For example; 82% of patients diagnosed with diabetes had had their blood pressure checked during the preceding year compared to the CCG average of 78% and the national average of 78%.

· Performance for mental health related indicators was similar to CCG and national averages. For example; 92% of patients who had a serious mental health condition had a documented care plan recorded in their record, compared to the CCG average which was 92% and the national average which was 88%

· The practice had achieved 86% for monitoring blood pressure for patients with hypertension in the preceding year. This was similar to the CCG and national averages which was 85% and 84% respectively.

The practice had identified that diabetes was an area where they could improve and had recruited two additional nurse practitioners and funded courses in chronic disease management in order to improve monitoring for patients diagnosed with diabetes.

The practice supplied their most recent QOF data from 2015/16 which showed that they had achieved 100% of the available points. Their anticipated exception reporting rate was in line with CCG and national averages. (This data had not yet been verified and published)

There was evidence of quality improvement including clinical audit. There had been 16 clinical audits completed in the last two years, 11 of these were completed over two cycles and the improvements made were implemented and monitored. For example; a two cycle audit was conducted to identify whether management against current guidelines and prescribing advice was being followed. The audit showed that at the end of the second cycle, there had been a reduction in antibiotics being prescribed for appropriate patients.

Effective staffing

The practice were committed to developing their staff to enhance their skills and improve the delivery of care and services to patients.

- The practice had recruited a physician's associate who was able to work alongside GPs to assess and treat patients. This had reduced the waiting time for routine appointments by two days.
- The practice had enabled two healthcare assistants (HCA) to develop clinical skills to NVQ level 3 and provide specialist clinical care including wound care, phlebotomy and basic chronic disease assessments with appropriate oversight and mentoring from a qualified nurse.
- They had funded a post graduate course for a practice nurse in advanced practice to enable chronic disease management and urgent care to be provided in the practice. This reduced the workload for GPs and improved access to care for patients seeking urgent care and had reduced waiting time for patients with a chronic illness by three days.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We looked at the records for recently recruited staff and found that an induction checklist had been completed.
- They had recruited a trainee advanced nurse through an initiative provided by their local care Commissioning Group (CCG) to provide a triaging service.
- There was an appraisal system in operation at the practice, and 100% of staff had received their appraisal in the preceding 12 months. There were development plans for staff.
- Staff were supported to undertake training to meet personal learning needs to develop their roles and enhance the scope of their work. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. Development for non-clinical staff included training specific to personal and individual development. Nurses were also given time and support to address their needs for nurse revalidation.
- All staff had received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and the computer system. This included care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services and where there was risk of unplanned admission to hospital.

The practice had developed their own risk stratification tool within the clinical system which enabled them to identify patients in the following criteria;

- Nursing home and care home patients
- Patients who have had falls
- Patients taking more than eight medicines
- Patients with a learning disability
- Patients being reviewed by the care coordinator
- Patients who had had multiple hospital admissions

Staff worked together with other health and social care services to understand and meet the range and complexity of people's needs, and to assess and plan ongoing care and treatment. This included when people moved between services, when they were referred, or after they are discharged from hospital.

The practice held six weekly multi-disciplinary meetings to review care for patients on the palliative care register which enabled 90% of patients on the practice's palliative care register died in their preferred place of death, with 10% dying in hospital or a hospice.

The care coordinator was able to arrange for patients to access help and assistance from a range of services including occupational therapy, physiotherapy, social services, voluntary sector, mental health team and citizens advice. There was also support available through referral to The Live Life Better Derbyshire programme. This included; exercise programmes, weight management programmes, advice about debt and housing, and smoking cessation support sessions. We saw evidence that multi-disciplinary team meetings took place on a monthly basis incorporating reviews of patients at risk of hospital admission, end of life patients, and those who had complex needs. These meetings included a GP, care coordinator, community health team representatives, (community matron, district nurse, health visitor), social work team and the community mental health team where required. Care plans were routinely reviewed and updated and risks assessed. In addition to the practice's usual care plan, patients with complex needs were provided with a Derbyshire Health and Social Care Plan which was comprehensive and shared with relevant services as required.

There was a good system in place for managing incoming correspondence, including test results. The GPs contacted patients directly to inform them of abnormal test results. All hospital discharge information was acted upon quickly, and any amendments to patients' medication following discharge were completed by a GP. Urgent referrals to secondary care were processed on the same day.

There was an efficient system in place for acting on information passed from the out of hours service. This was received electronically and the on call GP would review the information the next day.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Each of the 11 residential and care homes aligned to the practice had a named GP who visited each home monthly to plan care, conduct medication reviews, meet with patients, relatives and staff.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits. For example; a recent audit of patients who underwent minor surgery at the practice showed that 100% of patients provided consent for the procedure which was recorded in the patient record.

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.
- The practice had signed up to an out of area initiative whereby patients who worked in the locality, but lived outside of it, could register with the practice and see a GP during their working hours for health issues and prevention of ill health. The practice had 98 out of area registrations at the time of our inspection.
- Dietary advice and sign-posting to smoking cessation support services are available from the practice's wellbeing worker.

The practice's uptake for the cervical screening programme was 96%, which was significantly better than the CCG average of 84% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for breast cancer screening. They had achieved an attendance rate of 80% for breast cancer screening which was 2% higher than the CCG average and 8% higher than the national average. Screening for bowel cancer at 58% was comparable with CCG and national averages.

There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice had a dedicated administrator who actively followed up women who were referred as a result of abnormal results as well as those who did not attend their appointment.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 98% to 99% and five year olds from 92% to 99%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the 14 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

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

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%).
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%)
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%).
- 77% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%)

Care planning and involvement in decisions about care and treatment

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

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

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%

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

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

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 155 patients as carers which represents 1.2% of the practice list. A patient coordinator was the carers champion and was able to assist them with seeking the support they required through the Derbyshire Carers Association. Those with urgent or complex needs were referred to the care coordinator

There was also written information available in the waiting area to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service.

The practice held a charity coffee morning each year and encouraged patients and staff to bake cakes to raise money.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice served a population that was higher than average for older people, and had a higher percentage of people with a chronic illness. Because of this, they had configured their services to meet the needs of their population. In particular, they had aligned additional nurse resources for older people and those with a chronic illness as part of their strategy to improve health care for these groups and to reduce demand on GP resources.

For example,

- They had provided two practice nurses with specialist training for chronic diseases.This was to increase access to this service. Long-term condition reviews were co-ordinated to ensure that patients with more than one condition could be reviewed as part of one appointment.
- They had funded training to enable two HCAs to provide wound care and diabetes foot checks for patients. They had identified that there was a high demand for treating leg ulcers and so ensured that the HCAs had undertaken some of their placement experience at local podiatry and leg ulcer clinics..
- They had provided training for a HCA to enable her to provide phlebotomy services at the practice. This ensured that more patients could receive blood tests at the practice rather than travelling to a local hospital.
- The practice had 11 care homes aligned to them and the lead GP visited each month to conduct a ward round. A recent survey commissioned by Southern Derbyshire CCG was very positive about the relationships with the surgeries and care that patients receive.
- The practice had access to a falls prevention service that identified people who were at risk of falling. When a notification was received, the GP conducted a medication review and assessed the risk of fractures. Patients are also discussed at Multi-Disciplinary Team (MDT) meetings with care coordinator and referrals made via a single point of access for physiotherapy, occupational therapy and other services.
- The practice worked closely with the community matron to ensure that patients received the highest standards of care.
- The practice had recognised their under achievement for diabetes and COPD indicators during 2014/15 and had recruited and trained two additional practice nurses to provide chronic disease management. This had resulted in the practice achieving a total of 100% for diabetes related indicators and 100% for COPD related indicators for the QOF performance year 2015/16. (this data was supplied by the practice and has not yet been verified or published)
- The practice referred patients to a local memory clinic for support.
- They worked with community pharmacist to ensure that prescribing was appropriate. There was a delivery service for housebound and older patients.

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

- They had recruited a physician's associate (a clinician trained to post graduate level with skills to assess and treat patients under supervision of a GP.) This had the impact of reducing waiting times for routine appointments and urgent care. We saw evidence to show that waiting times for a routine appointment had reduced by two days since the introduction of the Physicians associate role. It also freed up some GP hours enabling GPs to see more patients with more complex needs
- They funded a practice nurse to undertake a post graduate course in advanced practice to enable her to undertake urgent care assessments
- They had recruited a trainee advanced nurse who was due to start work at the practice in October. The advanced nurse will provide on -the -day triaging. The impact was aimed at freeing up one GP each day and would enable an additional 120 GP routine appointments per week and 16 routine telephone appointments with GPs.
- They mentored a community pharmacist who worked with the practice to review medicines and was working towards an independent prescriber qualification. The impact of this was not yet known, however, it was anticipated that their work with regular medicines reviews and audits would free up some GP hours.
- The practice were collaborating with another practice in their locality to proactively plan for winter pressures and find solutions to manage increased workload and late

Good

Are services responsive to people's needs?

(for example, to feedback?)

requests for home visits. The impact of this was anticipated to be the ability to see and treat sick patients sooner and prevent avoidable or late admission to hospital.

- The practice had received training on dementia and were striving to become a dementia friendly practice. They had installed dementia friendly signage throughout the practice.
- As a result of patient feedback regarding access to appointments, the practice had implemented a triage system to manage on-the-day demand for appointments. This was GP led with nurse practitioners. This enabled patients to be prioritised according to clinical need, whilst still enabling patients to see their usual GP where possible. The triage system was communicated to patients via the PPG, television screen in the waiting room, website, local media, newsletter, posters and by inviting the local newspaper to run a feature.
- They had actively encouraged patients to book onto the online services and at the time of our inspection had 22% of their patients registered. They had received a commendation from the CCG and a request to assist lower achieving practices to achieve the CCG target of 10%.
- They had recruited a data clerk to follow up any non-attenders for routine health checks, baby checks, screening tests and immunisations. This had resulting in a higher achievement in patients receiving immunisations and screening tests.
- The waiting area contained a wide range of information on services and support groups.
- The layout of reception helped to maintain patient confidentiality. A separate room was usually available for private and sensitive discussions.
- There was a phlebotomy service that included anti-coagulant therapy. (anti-coagulant therapy is a medicine to thin the blood to help prevent clotting)
- A child health clinic is commissioned locally at a neighbouring health centre and the health visitor attends the practice regularly for meetings with practice staff
- A representative from the Citizens Advice Bureau attended to provide advice on benefits.
- Appointments were available throughout the day. There were longer appointments available for patients who required them, and telephone consultations were available.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The premises provided suitable entrance doors for patients in wheelchairs, or those with limited mobility. Services were provided over two floors, and a lift was provided. There was a disabled toilet available for disabled patients and a hearing loop was available for patients who had hearing difficulties. The practice provided some higher chairs for patients who had difficulty in standing from a low seat.
- Translation services were available for patients whose first language was not English.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 12pm and afternoon appointments were offered from 3pm until 5.30pm. There were extended hours offered from 7am for phlebotomy services and the practice sees additional patients at the end of the clinic session until 6.30pm if necessary. Home visits and telephone consultations are provided throughout the day.

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

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

- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and the national average of 76%.
- 57% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 73%.

The practice told us that this response had prompted them to act to improve patient access to appointments and had since implemented the triaging system.

Good

Are services responsive to people's needs?

(for example, to feedback?)

They were aware of the difficulty in getting through to the practice early in the morning and were looking at ways to improve this by changing their telephone system once the contract was near the end.

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

The practice had a system in place to assess:

- whether a home visit was clinically necessary
- the urgency of the need for medical attention

Triaging was provided by GPs and nurse practitioners who had received training in triage and assessment skills. Where an appointment was required on the same day, patients were offered an appointment with their usual GP wherever possible to ensure continuity of care.

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

Listening and learning from concerns and complaints

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

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

We looked at 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, further to a complaint, the practice had reviewed their protocol for keeping some items of equipment that are usually brought in by the patient following discharge from hospital.

The practice reviewed complaints in regular practice and also held an annual review of complaints to discuss lessons learned and to check whether changes to practice had been fully embedded.

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

- A 10 year vision
- A resourcing plan
- A succession plan
- Development of the practice's training location status
- Flexible working across roles
- Collaborative working plans with other practices
- Working with medical students
- Mentorship and courses for relevant staff.

The partners recognised the need to invest in their staff and arranged for an annual away day for all staff as well as an annual strategy day for partners. They were also keen to support training and development across all staff levels.

They were proactive in looking for new ways to approach clinical capacity issues and had recruited to a number of new roles in order to enable better access to appointments and for GPs to be freed up to see more complex cases. New roles included;

- Physicians Associate
- Advanced Nurse
- Community Pharmacist (mentored by the practice)
- Enhanced roles for HCAs
- Enhanced roles for practice nurses
- Nurse Practitioner/triage nurse.

The partners were motivated to develop the practice and embrace local initiatives wherever possible; For example;

- Striving to achieve dementia friendly status
- Collaborating with another practice to plan for winter pressures
- Striving to achieve Gold Standard Framework accreditation for palliative care
- Hosting school visits at the practice and providing health education at local schools to promote healthy lifestyle
- The practice was selected to pilot the role of pharmacist in general practice and had mentored a pharmacist from the community to undertake independent prescriber qualifications. Results of the pilot had not yet been published, but it was anticipated that the new role would impact on the clinical capacity for the practice and reduce the workload for GPs.
- Implementation of new clinical roles

Governance arrangements

The practice had systematic approach towards governance and this enabled the providers to assess, monitor and improve services and to take action to mitigate risk.

- There was a clear staffing structure and a strong commitment to ensuring that staff developed their skills and that this improved the range of services available to patients, for example the Physician's Associate and developing two HCAs to extend the services offered to patients. All staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented, regularly reviewed and updated and were available to all staff electronically.
- The practice engaged with their CCG, took part in pilots, attended locality meetings and the practice managers' forum to work collaboratively and share best practice. Attached staff were invited to training to improve collaborative working and to improve patient outcomes, for example training in end of life care had resulted in 90% of patients dying in their preferred place.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There was a systematic approach towardsmeetings that enabled all staff to contribute to the performance and development of the practice
- The practice used information from safety and MRHA alerts and development needs to drive a programme of continuous clinical and internal audit, which was used to monitor quality and to make improvements.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and

Are services well-led?

Outstanding ☆

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

compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff. Community staff felt included and valued by the practice.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support and training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment, they gave affected people reasonable support, information and a verbal and written apology

The partners and clinical staff met for a dedicated coffee meeting each day where they discussed potential issues and concerns for the day and adjusted their work plans according to the needs of the whole team and any emerging problems. Non clinical staff and attached community staff told us that they felt able to join this meeting whenever they needed to discuss an urgent need for a patient, or any other concern.

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 conducting surveys and complaints received and from the patient participation group (PPG) The PPG met monthly and participated in a monthly walk around the practice to check that the environment was being maintained. The PPG were also active in communicating changes to patients, for example; when the new triaging system was implemented.
- The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and worked with others to improve outcomes for patients in the area. For example; planning for winter pressures with another practice in the locality.

Reception and administration staff were provided with additional training to increase their skills sets and enable flexibility among the teams.

Staff were proud of their achievements and were motivated to continually develop and improve care for patients.