Swadlincote Surgery

Quality Report

Darklands Road
Derby
DE11 0PP
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection October 2016 – Outstanding)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Swadlincote Surgery on 14 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Clinicians followed national guidelines and protocols available to them in the identification and management of severe infections such as sepsis.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care at the right time.
- The practice was a training practice and the partners were proud of their reputation for being a practice of choice for trainee GPs and other clinical roles.
- Results from the latest national GP patient survey showed that the practice had performed above local and national averages in the majority of the questions about patient experience. This was particularly evident in relation to GP access and comments regarding being listened to and having tests and treatments explained.
- Care planning was embedded within the practice to reflect individual patients' needs and their own

Summary of findings

wishes. We saw that care plans were thorough and were used extensively for patients in care homes, those with complex needs and patients who were vulnerable.

- The practice was responsive to patient's feedback and had invested in a new telephone system with an additional line to improve access for appointment requests.
- They had implemented a Medical Interoperability Gateway system (MIG) which enabled the sharing of specified datasets of patient information between healthcare providers in 'real time' to enable a more effective response for relevant healthcare professionals.
- The practice utilised a care coordinator who worked with the practice and community team to identify patients who were at risk of unplanned admission to hospital.
- The practice utilised data clerks to manage the recall system and free up time for nurses to manage their time more effectively. They contacted non-attenders by telephone to re-schedule their appointment
- They had set up an internal Locum system to enable consistency of care for patients
- The partners and practice staff were very proud of their reputation for being highly regarded as an excellent training practice and able to recruit new GPs and other clinical staff easily as trainees and also for permanent positions.
- Some of the GP partners held strategic lead roles within the clinical commissioning group (CCG) which helped influence and drive improvement in the delivery of patient care within the locality.
- The practice were proactive in identifying risk of falls and taking action to reduce this. All GPs used a fragility index score for patients at risk and created a care plan for those patients which was shared with relevant health care providers.
- The practice had achieved dementia friendly status
- The practice had created effective links with local schools and universities to assist young people who were interested in a medical career, as well as providing training and mentorship for GP Registrars and advanced clinical practitioner (ACP). They also worked collaboratively with Derbyshire Community Healthcare Services (DCHS) to provide training and mentorship for an additional ACP.
- They had designed an ANP triage hub and were about to commence this as a pilot project. Patients would benefit by seeing an ANP with a specialism most suited to their symptom and would receive the most appropriate advice first time.
- They had developed a support board in the reception area to 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 and homeless people.
- The practice had developed their own risk stratification tool within the clinical system to identify patients who were vulnerable for a variety of reasons.
- The practice had recently set up a bereavement café to help bereaved relatives feel less isolated.
- A workshop for new parents had been set up and due to commence the following week for the first time. The anticipated impact of this was that new parents would be better informed to manage their child's health. This would potentially improve attendance for scheduled child health checks.

We saw an area of outstanding practice:

- The practice worked with their local CCG to reduce waiting times for local mental health provision. This had resulted in a reduction in waiting times for patients to receive access to psychological therapies within six weeks from 66% to 76% of patients. Many were seen within four weeks of referral.

The area where the provider should make improvement are;

- Ensure that all mandatory training updates are completed by relevant staff and are recorded centrally.

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

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

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, a practice manager adviser and an inspection manager.

Background to Swadlincote Surgery

Swadlincote surgery provides primary medical services to 13,961 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 10 GPs (five male and five 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, three practice nurses, three health care assistants and one advanced clinical practitioner 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 who treat patients registered with the practice are based on site.

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

A GP Partner is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The practice address is; Darklands Road, Derby, Derbyshire. DE11 0PP

www.swadlincote.gpsurgery.net

The practice is registered with CQC to provide the following services;

- Diagnostic and screening procedures
- Treatment of disease, disorder and injury
- Surgical procedures
- Midwifery and maternity
- Family planning services.

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice had 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. Staff at all levels told us that they were very aware of the need to report any concerns. This included staff who did not have direct contact with patients. An example provided showed that staff used a safety netting approach which alerted them to potential concerns and routinely reported these to the relevant person.
- 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). 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 meetings held in 2017. The meetings minutes were consistent over time demonstrating a safe track record over the long term.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- 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). A poster was displayed in the waiting area which advised patients that chaperones were available if required.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. However, we noted that staff files for recently recruited staff were incomplete with regards to some recruitment information for a GP partner. The practice informed us that the information had been obtained and checked but not yet added to the individual file.
- There was an effective system to manage infection prevention and control. The infection prevention and control (IPC) lead was a nurse practitioner who had recently been appointed to the role. She had already completed an audit in July 2017 and written an action plan to make some improvements. However, we noted one omission from the action plan with regard to a hand basin in one treatment room that did not comply with regulations due to the type of taps used. The IPC Lead had received some training and was scheduled to attend further training relevant to the IPC lead role in 2018.
- The practice ensured that facilities and equipment were safe and in good working order. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed through the use of a rota system. The partners had recently agreed minimum working levels for GP partners so that clinical rotas could be prepared more in advance. This also ensured consistent clinical cover within the practice whilst allowing for flexibility for GPs to attend their other clinical commitments, professional interests and development.
- There was an effective induction system for newly recruited staff
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. The practice had recently experienced a serious emergency on the

premises and staff told us how proud they had all felt when reflecting on how the team had responded so quickly and effectively to bring about a satisfactory outcome for the patient.

- Reception staff knew to inform a triage clinician immediately if they felt a patient looked very unwell when presenting at the desk and had access to urgent care guidelines for patients who may be presenting with urgent symptoms such as chest pain.
- Clinicians followed national guidelines and protocols available to them in the identification and management of severe infections such as sepsis. We saw that these guidelines had been discussed at practice meetings and a risk assessment template was used to assist them, which was automatically activated when certain clinical indicators were recorded within the patient record. This served as a prompt to alert the GP or nurse to complete the sepsis risk assessment.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. They had implemented a Medical Interoperability Gateway system (MIG) which enabled the sharing of specified datasets of patient information between healthcare providers. The provider told us that this improved patient safety because it provided other relevant clinicians with real-time access to up to date information such as medications, allergies, test results and prescriptions issued. The provider also felt that having timely access to clinical information improved patient care and clinical efficiency.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- The practice had systems to ensure that incoming patient discharge letters and pathology results were seen by a GP each day. These were distributed to each of the relevant GPs and where a GP was absent, these were shared between the other GPs on the day. We noted that there was no backlog of letters or test results that required GP review. Once reviewed, the GP tasked the administration team with the relevant action and we noted that these were dealt with within 48 hours in most cases.

Appropriate and safe use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- The practice monitored use of prescription stationery and kept consulting rooms locked when not in use. However, we noted that some stationary was not routinely removed from printers in consulting rooms at night. The provider told us they would make immediate changes to this following our inspection.
- There was a protocol in place for the safe management of controlled drug prescriptions. Staff adhered to a repeat prescription pathway developed by the practice to ensure any repeats requested were only issued with correct authorisation. Uncollected prescriptions were reviewed each month and patients were followed up when this was necessary to make sure they had access to their prescribed medicines.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. There was evidence of actions taken to support good antimicrobial stewardship. This included discussions at practice meetings and an audit of prescribing of certain antibiotics over two cycles to check adherence to guidelines. The audit showed an improvement of prescribing certain antibiotics to within targets set by Southern Derbyshire Clinical commissioning Group (CCG).
- The practice had a robust and safe process to ensure any patients being prescribed high-risk medicines were being monitored closely.
- The practice involved patients in regular reviews of their medicines. Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately.

Track record on safety

The practice had a good safety record.

Good

Are services safe?

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and felt supported by management when they reported an incident. The practice discussed significant events at weekly practice meetings and learning was shared with individuals where relevant and with all staff via notifications and at meetings. They also held an annual review of significant events and made the log of outcomes for these accessible to all staff on the computer system. We noted that there was no policy or written protocol for managing significant events, however, all staff we spoke with understood how to report one and told us how they heard about lessons learned from these. For example; when a delay in making an urgent referral occurred, the practice looked at their systems and amended their practice to include a shortcut for urgent referrals.
- There was a system for receiving and acting on patient and medicine safety alerts. There was a practice protocol to support the dissemination and response to incoming alerts. We saw evidence that when medicines alerts were received, searches were undertaken to identify patients this might affect, and these were then followed up and reviewed accordingly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups

The practice had previously been rated as outstanding for providing effective services for older people and people with a chronic illness. This was mainly due to the practice's efforts in resolving recruitement and clinical capacity issues. They had adjusted the skill mix of their staff so they were able to provide alternative ways of providing clinical care. This had led to reduced waiting times for patients with a minor illness and those with a chronic illness by two to three days. On this inspection we found the physicians associate was no longer in place, but that the practice had increased capacity in other areas. However, we unable to evidence the impact of this.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance.

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Clinicians were able to describe examples of recent discussions held in relation to new or updated guidance, and we saw that this was used to inform the practice's audit programme.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. There was extensive use of individualised care planning with the wider health care team. These care plans were accessible through the practice's use of the Medical Interoperability Gateway system (MIG) which enabled relevant health professionals to access certain parts of the patient record in 'real time' in order to assist them provide care quickly and effectively.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- 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.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Older people:

- The practice utilised a care coordinator who worked with the practice and community team to identify patients who were at risk of unplanned admission to hospital.
- All patients were contacted following hospital admission to help identify any additional support that may be needed
- 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.
- They worked with community pharmacist to ensure that prescribing was appropriate. There was a delivery service for housebound and older patients.
- The practice had 11 care homes aligned to them and each had a lead GP who visited their allocated care home each month to conduct a ward round.
- Patients aged over 75 were invited for a health check and if necessary, referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice had carried out health checks for 86% of eligible people.

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 with long-term conditions had a structured annual review to check their health and medicines

Good

Are services effective?

(for example, treatment is effective)

needs were being met. For patients with the most complex needs, the clinicians worked with other health and care professionals to deliver a coordinated package of care.

- Two HCAs had been trained in providing basic assessments for chronic illness management, which included foot checks. This initial review contributed to patient's overall health check which reduced the amount of time required with a qualified nurse for some patients
- The practice had achieved 100% of available QoF points during 2016/17 with each of the 10 indicators for diabetes being above the CCG and national averages. Exception reporting was below CCG and national averages for almost all of the indicators.
- The practice had achieved 100% of available QoF points for asthma, however, exception reporting at 10% was slightly higher than the CCG and national averages for two of the three indicators for asthma.
- A total of 94% of patient with COPD had received a assessment of breathlessness within the preceding 12 months, which was marginally above CCG and national averages. They had achieved this with an exception reporting rate that was in line with CCG and national averages for this indicator.
- The practice utilised two data clerks to manage the recall system and free up time for nurses to manage their time more effectively. They had also recently implemented a protocol to contact non-attenders by telephone to re-schedule their appointment and were in the process of evaluating this.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above. Most of these were above 94%
- The practice provided emergency contraception, and offered family planning services.
- Monthly meetings were held with health visitors and school nurses to review any children where there were any known safeguarding concerns. GPs contributed to requests for child protection case conferences and the multi-agency risk assessment conference (MARAC), where information is shared on the highest risk domestic abuse cases between representatives of local agencies such as the police, health and social care providers.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medication.
- The practice offered 30 minute appointments for 6 week baby checks. Any non-attenders were followed up by the care coordinator to re-schedule the appointment.
- One of the GP partners had visited a local school to talk to children about their heart, with the aim of helping children understand the importance of looking after their health
- School age children are offered appointments outside of school time if clinically appropriate.
- The practice has increased their nurse practitioner team to enable prompt triaging and enable prompt same day care by an appropriate clinician for patients with acute illnesses.
- The practice were planning a workshop for new parents led by a GP partner to help parents understand more about common minor childhood ailments and when to ask for help.

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

- The practice's uptake for cervical screening was 94%, which was significantly higher than the 80% coverage target for the national screening programme.
- Students between the ages of 17 – 19 years were encouraged to have the MenC vaccination (to protect against meningitis and blood poisoning) before going to University for the first time. They were sent for prior to the new intake in September. The practice promoted Fresher Meningitis MenACWY Vaccination on Social Media
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74.
- The practice promoted patient online access to assist patients with limited time to access the surgery in normal working hours
- The practice registered patients who lived out of the area but who worked locally.

People whose circumstances make them vulnerable:

Good

Are services effective?

(for example, treatment is effective)

- All new cancer diagnoses were reviewed every 6 weeks in an end of life meeting that included relevant members of the MDT and took into account individual needs such as the patients preferred place of care.
- The practice held a register of patients with a learning disability which showed that prevalence was slightly higher than CCG and national averages. 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 and nurse worked very closely with the community lead for learning disabilities. The practice had completed annual health reviews for 44 of the 45 patients invited from their 90 patients on the register during 2016/17, which was in line with local and national averages.
- Longer appointments were offered for patients who were vulnerable and where access may be more challenging for them. An alert was used to flag patients who required additional support.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had strong local links with the voluntary sector and included representatives in locality meetings

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

- 75% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months, which is comparable to the national average
- 98% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months, which is higher than the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. For example, the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 98%; CCG 90%; national 90%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 93%; CCG 94%; national 95%).

Monitoring care and treatment

The most recent published Quality Outcome Framework (QOF) results were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 94%. The overall exception reporting rate was 11% compared with a CCG average of 11% and a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

The practice used information about care and treatment to make improvements and was actively involved in quality improvement activity which included clinical audits. There had been five clinical audits completed in the last two years, one of these was 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 with the national targets set.

Where appropriate, clinicians took part in local and national improvement initiatives. For example;

- The practice were implementing a triage hub for clinicians which was led by a GP partner.
- They had set up an internal Locum system to enable consistency of care for patients
- A GP partner had planned a workshop for new parents, the first was scheduled to take place in the same month we visited.
- The practice had recruited one advanced clinical practitioner (ACP) and was providing mentorship and clinical support for a second ACP in collaboration with a local commissioner who funded this role.
- The practice encouraged carers to attend for an assessment with Derbyshire Carers Association, which was held one day each month at the practice. This enabled carers to improve their general wellbeing by accessing various aspects of support relevant to their individual needs.
- The practice had achieved dementia friendly status.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. All staff were invited to monthly protected time sessions where the practice closed for one afternoon each month for learning development sessions. Records of skills, qualifications and training were kept in individual files, however, there was no central oversight of this. The practice provided evidence of how they had resolved this shortly after the inspection. There was a central record held for all mandatory training and updates that was accessed online. However, this showed that some staff were not up to date with some refresher training modules that the practice had deemed as being mandatory. The practice gave assurance that additional time had been scheduled for those staff to complete the relevant modules by the end of the December 2017. Staff were encouraged and given opportunities to develop and this was supported financially where required.
- The practice provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice could demonstrate how they ensured the competence of staff employed in advance roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice had invested in high staffing levels in recognition that this was essential to provide quality and continuity. Staff were trained to provide them with the necessary skills to undertake the role of health care assistant (HCA) and received ongoing mentorship and support.
- The practice was a teaching practice and supported a clinician who was training to become an advanced clinical practitioner (ACP). They were also providing mentorship for a second ACP who they had recently recruited.
- Development for non-clinical staff included training specific to personal and individual development.

Coordinating care and treatment

All appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

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

There was a GP lead responsible for ensuring that palliative care was delivered effectively and kept relevant staff up to date with standards for end of life care. The practice held six weekly multi-disciplinary meetings to review care for patients on the palliative care register which enabled 94% of patients on the practice's palliative care register who had died in their preferred place of death during the preceding 12 months.

Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

Good

Are services effective?

(for example, treatment is effective)

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns.
- 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.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice utilised social media to promote health awareness events such as antibiotics awareness week, safety on bonfire night, back care awareness week, and a workshop for new parents.

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Staff understood patients' personal, cultural, social and religious needs.

- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The care coordinator had recently set up a bereavement café at the practice to help bereaved relatives feel less isolated. This impact of this initiative had not yet been evaluated at the time of our visit.
- There was a dedicated notice board for carers and a package of care available. The practice actively encouraged all staff to identify any carers who may be suffering from fatigue or stress.
- The practice utilised promotional information in the waiting room and on their website to help patients understand the accessible information standards. Staff had been trained to check with patients whether they had any specific information or communication needs.
- All of the 23 Care Quality Commission patient comment cards we received were positive about the service experienced. Two cards included a negative comment relating to access to appointments.

Results from the July 2017 national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 223 surveys were sent out and 89 were returned. This represented 40% of the practice population. The practice was above average for all of its satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 90% of patients who responded said the GP gave them enough time; CCG - 87%; national average - 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 88% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 95% of patients who responded said the nurse was good at listening to them; (CCG) - 92%; national average - 91%.
- 95% of patients who responded said the nurse gave them enough time; CCG - 92%; national average - 92%.
- 97% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 96%; national average - 95%.
- 92% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 78% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average - 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, communication aids (such as a hearing loop) and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.
- The practice asked new patients to complete a questionnaire to identify whether they required additional help or assistance. This was then added to the patient record, which was available for all staff to see as an alert.
- There is also a notice regarding access and information standard in the waiting area

The practice proactively identified patients who were carers, and the list was reviewed on a regular basis to ensure it was kept updated. The practice's computer

Good

Are services caring?

system alerted GPs if a patient was also a carer. New patients were asked whether they were a carer as part of the registration process. The practice had identified 188 patients as carers (1.4% of the practice list).

- The care coordinator acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.
- The practice hosted monthly events for Derby Carers Association to see patients who were also carers and assess their needs.(financial, emotional and wellbeing needs)
- Staff told us that if families had experienced bereavement, either a member of the practice team contacted the family or carer. This call was either followed by a patient consultation (if required) and/or by giving them advice on how to find a support service. A bereavement café was in the process of being set up.

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 above local and national averages in some areas:

- 92% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 88% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 83%; national average - 82%.
- 94% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 84% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, and advanced booking of appointments.
- The facilities and premises were appropriate for the services delivered.
- The practice were able to describe how they accommodated individual needs. They had made reasonable adjustments when patients found it hard to access services. They had developed an additional support board in the reception area to 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 and homeless people.
- The practice told us that they had increased their GP capacity, and at the time of our inspection had 10 GP partners, each with a whole time equivalent ratio of 1750 patients per GP.
- The practice were proactive in identifying risk of falls and taking action to reduce this. All GPs used a fragility index score for patients at risk and created a care plan for those patients which was shared with relevant health care providers.
- There was a dedicated quiet room available for breastfeeding.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice had implemented an internal locum system to improve continuity of care for patients and enable better management of GP rotas. The practice had also agreed a minimum working hours requirement for GPs so that rotas can be fulfilled more in advance.
- The practice had worked on improving the triage process for patients. The practice had provided additional training for two advanced nurse practitioners (ANP) to improve their skills and knowledge relating to telephone triage. They had designed an ANP triage hub and were about to commence this as a pilot project. Three ANPs and one advanced clinical practitioner (ACP) would work together in a 'hub' room with nearby consultation rooms for face to face consultations. It was anticipated that the combined specialities of the team would enhance the effectiveness for patients and provide an opportunity for the team to share and 'pool' their knowledge. Patients would benefit by seeing an ANP with a specialism most suited to their symptom and would receive the most appropriate advice first time. The new triage hub was due to start in November 2017.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or at an adult social care service.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice provided care for residents at 11 local care homes. Monthly visits were made to the home by a named GP and any urgent requests were responded to on the day. They had allocated a second GP for care homes with patients who had complex needs so that continuity of care could be provided more easily. Emergency admissions had reduced as a result from 68 admissions in 2016 to 18 admissions during 2017 to date. (the 2017 data is for eight months and will be updated at the end of the year).
- 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 were 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.

People with long-term conditions:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment and consultation times were flexible to meet each patient's specific needs.
- The practice had trained a nurse practitioner to post graduate level to provide chronic disease management and triage. HCAs had been trained to provide basic chronic disease management and conduct foot checks. This reduced the time needing to be spent with trained nurses on the basic aspects of the health check and allowed for more time to focus on discussing how to manage and improve their condition.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice had identified a need to improve their processes for recalls and recently implemented a protocol to contact non-attenders by telephone to re-schedule their appointment and were in the process of evaluating this.
- 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.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All children were offered a same day appointment when necessary.
- A GP Partner had organised a Workshop for new parents at the practice to address concerns over childhood illness and help to improve confidence in managing common childhood ailments. The first of these sessions was due to be held on the same week as our visit and will be evaluated over time.
- A GP visited a local primary school to teach children about their heart and to promote a health lifestyle.

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

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours.
- Early morning appointments for phlebotomy and some nursing procedures were available from 7am Monday to Friday.
- Access to GP appointments was monitored continuously to ensure that patients did not wait more than a few days for a routine appointment.
- The practice registered out of area patients to accommodate the working population being able to access healthcare and annual reviews at a surgery close to their place of work or study.
- The practice implemented a new protocol for processing requests for sick notes in order to provide a more consistent and efficient service. Information has been made available on their website and patient information leaflets have been produced.
- Online access was available for repeat prescriptions and appointment booking.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice was aligned with two care homes for people with a severe learning disability and conducted monthly ward rounds, as well as responding to any urgent needs in-between. Each care home had at least one named GP.
- The practice had increased the number of clinical staff who can undertake learning disability reviews. The practice regularly reviewed protocols and recall systems to improve uptake in difficult to reach patients.
- 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 and homeless people.
- The practice hosted a well-being worker on site. GPs and other clinical staff referred patients to the 'Live Life Better Derbyshire' programme for support in aspects of their lives to improve health and wellbeing, for example smoking cessation and weight management programmes. Patients could also self-refer using the leaflets available in the waiting room.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 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):

- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.
- The practice had dementia friendly status and the practice team had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice worked with their local CCG to reduce waiting times for local mental health provision. The practice had identified that only 66% of patients had waited less than six weeks to access psychological therapies in the preceding months. (the target was 75% to access care within six weeks of referral). The practice confirmed that from October 2017, 76% of patients referred for psychological therapies had started treatment within 6 weeks of referral, and many of these were seen within four weeks.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use and accessible in a number of ways.

Results from the July 2017 national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 223 surveys were sent out and 89 were returned. This represented 40% of the practice population. Responses in almost all of the questions asked provided a higher satisfaction rate than CCG and national averages.

- 80% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 61% of patients who responded said they could get through easily to the practice by phone; CCG – 67%; national average - 71%.
- 85% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 84%; national average - 84%.
- 83% of patients who responded said their last appointment was convenient; CCG - 81%; national average - 81%.
- 60% of patients who responded described their experience of making an appointment as good; CCG - 71%; national average - 73%.
- 67% of patients who responded said they don't normally have to wait too long to be seen; CCG - 61%; national average - 68%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 15 complaints were received in the last year. We reviewed 2 complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example; when there had been a delay in sending a sample for testing, an apology was made and the issue investigated, this resulted in an amendment to practice to avoid samples being missed in the future.

Are services well-led?

Good

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

Our findings

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

The practice had previously been rated as outstanding for providing well-led services for older people and people with a chronic illness. This was mainly due to the practice's efforts in resolving recruitment and clinical capacity issues. They had adjusted the skill mix of their staff so they were able to provide alternative ways of providing clinical care. This had led to reduced waiting times for patients with a minor illness and those with a chronic illness by two to three days. On this inspection we found the physicians associate was no longer in place, but that the practice had increased capacity in other areas. However, we unable to evidence the impact of this.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it. Clinical leadership was directed by GPs undertaking specific lead responsibilities such as prescribing, QOF and safeguarding.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The practice had held annual strategy meetings in recognition of the changing nature of general practice and the requirement to adapt from the traditional practice management role.

Vision and strategy

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

- There was a clear vision and set of values. It had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. Staff were aware of and understood these.
- The strategy was in line with health and social priorities across the region.
- The practice planned its services to meet the needs of the practice population and monitored progress against delivery of the strategy.
- The practice had invested in the practice team with higher numbers of staff in comparison to many other similar sized practices and was committed to developing staff and utilising a flexible workforce to meet the changing needs of patients.
- All 10 partners had a 'portfolio partnership' whereby each was committed to working with other stakeholders and organisations to pursue personal and professional interests and develop expertise and specialities within the practice.

Culture

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

- Staff stated they felt respected, supported and valued. They told us that they enjoyed their work and were proud to work in the practice.
- The practice focused on the needs of patients. All staff were able to raise a concern about a patient's welfare, and receptionists were proud of their frontline role in being able to alert clinical staff to a potential concern about a patient.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. We saw evidence to confirm this when reviewing incident reports.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.

Are services well-led?

Good

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

- There was an emphasis on the safety and well-being of all staff. All staff we spoke with told us that they enjoyed working at the practice and was one of the happiest places they had worked.
- Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams. Attached staff we extremely positive about the support they received from the partners and staff and felt included as part of the team.
- The practice was committed to teaching and training and had created effective links with local schools and universities to assist young people who were interested in a medical career, as well as providing training and mentorship for GP Registrars and advanced clinical practitioner (ACP). They also worked collaboratively with Derbyshire Community Healthcare Services (DCHS) to provide training and mentorship for an additional ACP.
- The partners and practice staff were very proud of their reputation for being highly regarded as an excellent training practice and able to recruit new GPs and other clinical staff easily as trainees and also for permanent positions.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities.
- There was a schedule of regular in-house meetings that included relevant attached staff and other stakeholders.
- Some of the GP partners held strategic lead roles within the clinical commissioning group (CCG) which helped influence and drive improvement in the delivery of patient care within the locality.
- The practice worked collaboratively with other practices in the locality as part of the CCG Quality in a Place initiative.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of actions taken to resolve concerns and improve quality.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. This was supported by a practice intranet system which included alerts to ensure that review dates were scheduled and acted on.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. The practice had been commended for their response to a recent NHS cyber-attack where they were able to regain running of the service quickly. They were also able to assist other practices in the local area to resolve the issue and maintain a safe service for patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information via the practice's computer system.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and

Are services well-led?

Good

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

data management systems. This included provision of live data to other relevant healthcare professionals through a MIG system that had been implemented to improve data sharing more efficiently.

Engagement with patients, the public, staff and external partners

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

- The practice encouraged feedback from patients, staff and external stakeholders to shape services and culture.
- There was an active patient participation group. We spoke with members of the PPG who informed us that the PPG had monthly meetings with practice representatives, including a GP partner and the practice manager. The PPG representative told us that the group was treated respectfully and was listened to by the practice. The practice was open with them when things had gone wrong and that they were consulted on issues that impacted upon patients, for example; recruitment of new GP partners and other staff.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example; the practice closed for one afternoon each month to enable all staff to attend for meetings and development.
- The practice was proud of its achievements as a training practice for qualified doctors to train as a GP and for other clinical roles. For example; training and mentoring advanced nurse practitioners, advanced clinical practitioners and HCAs in collaboration with local universities and other external stakeholders.
- There was a GP partner who had a lead role in providing training for GP registrars.
- Staff knew about improvement methods and had the skills to use them. Mentorship was utilised as an important aspect of learning and development for new staff, trainees and as an ongoing resource for clinicians.
- The practice made use of internal and external reviews. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice worked with another surgery in the area to learn from one another's successes and share resources in relation to management of palliative care.
- The practice worked with young school leavers from years 10 and 12 who were interested in following a career in medicine.