Stewart Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Stewart Medical Centre on 1 August 2016. Overall, the practice is rated as good.

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

- There was a system in place for the reporting and recording of significant events. Learning was applied from events to enhance the delivery of safe care to patients.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- A programme of clinical audit reviewed patient care and ensured actions were implemented to improve services as a result.
- The practice planned and co-ordinated patient care with the wider multi-disciplinary team to deliver effective and responsive care to keep vulnerable patients safe.
- The practice had an effective appraisal system in place and was committed to staff training and development. The practice team had the skills, knowledge and experience to deliver high quality care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. The practice analysed and acted on feedback received from patients.
- Patients mainly provided positive views on their experience in making an appointment to see a GP or nurse.
- The practice offered a range of options to consult with a clinician. A GP triaged calls for requests to be seen on the day, and ensured that any patient requiring an urgent appointment was seen. Appointments could be booked in advance and telephone consultations were available. Longer appointments were available for those patients with more complex needs.
- The practice was maintained to a high standard with good facilities and was well-equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and the practice had a governance framework which

Summary of findings

supported the delivery of good quality care. Regular practice meetings occurred, and staff said that GPs and managers were approachable and always had time to talk with them.
- The practice had submitted a successful funding request to pilot two dementia support workers within primary care. The pilot scheme was to be formally evaluated to assess the outcomes it had achieved for patients and their carers.
- Information about how to complain was available upon request and was easy to understand. Improvements were made to the quality of care as a result of any complaints received.

We saw the following area of outstanding practice:

- The practice had developed an expert patient programme. This enabled patients with a new diagnosis to be able to speak with another patient with personal experience of dealing with the same condition.

The areas where the provider should make improvement are:

- The practice needed to ensure that records clearly documented the follow-up actions taken with children who could be vulnerable, and had not attended a hospital appointment.
- The practice reviewed patients who had been prescribed high-risk medicines and there was monitoring in place to ensure prescribing remained safe. The system in place needed to be strengthened to ensure that reviews were always undertaken within recommended timescales.
- Review the documented evidence to support staff induction programmes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Staff reported all significant events, and learning was applied from incidents to improve safety in the practice.
- The practice had robust systems in place to ensure they safeguarded vulnerable children and adults from abuse.
- The practice worked to written recruitment procedures to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- Risks to patients and the public had been identified with systems in place to control these. For example, the practice had a designated infection control lead who undertook regular audits.
- There were effective systems in place to manage medicines and prescriptions kept on site appropriately.
- There was evidence in place to support that the practice reviewed those patients who had been prescribed high-risk medicines and there was monitoring in place to ensure prescribing remained safe. The system needed to be strengthened to ensure reviews were always undertaken within the recommended timescales as a small number fell slightly outside of these.
- Actions were taken to review any medicines alerts received by the practice, to ensure patients were kept safe.
- The practice had robust systems in place to deal with medical emergencies.
- The practice ensured staffing levels were sufficient at all times to meet their patients' needs.
- The practice had developed contingency planning arrangements, supported by a comprehensive and up to date written plan.

Are services effective?

Good

- The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The practice had acquired a total achievement of 87% for the Quality and Outcomes Framework (QOF) 2014-15. This was

Summary of findings

below the CCG average of 98.1%, and the national average of 94.7%. However, the practice had identified a plan to improve their performance and we saw evidence that this was being successful.
- A programme of clinical audit demonstrated quality improvement, and we saw examples of how audit was being used to enhance safe patient care and treatment.
- All members of the practice team had received an annual appraisal, which included a review of their training needs. Staff had the skills, knowledge and experience to deliver effective care and treatment. New employees received inductions, although documented evidence of this was not sufficiently robust.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs, in order to deliver care effectively.
- A daily informal clinical meeting was held to address any problems that had emerged during the morning. This helped to get issues resolved quickly and provided a valuable source of support for clinicians.
- The practice received regular input from a CCG pharmacist that provided robust support on prescribing issues. From a patient perspective, this helped compliance with prescribed medicines and the practice had high usage of dosette boxes.
- The practice reviewed all patient deaths on a monthly basis to consider any learning and to share good practice.

Are services caring?

Good

- We observed a patient-centred culture and approach within the practice. Staff treated patients with kindness and respect, and maintained their confidentiality throughout our inspection.
- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated they were treated with compassion, dignity and respect and felt involved in decisions about their care and treatment.
- Data from the latest GP survey showed that patients generally rated the practice in line with local and national averages in respect of care.
- Feedback from community based health care staff and care home staff was positive about the high standards of care provided by the practice team.
- The practice had identified 1.3% of their list as being carers, which was in line with expected averages. Information was available on the various types of support available to carers.

Summary of findings

Are services responsive to people's needs?

Good

- Comment cards and patients we spoke with during the inspection provided generally positive experiences about obtaining an appointment with a GP, or being able to speak to someone regarding their concerns. The latest GP patient survey showed that patient satisfaction was generally higher or in line with local and national averages with regards access to GP appointments.
- There was in-built flexibility within the appointment system including pre-bookable slots; telephone consultations; and 'on the day' appointments for those with an urgent need. A GP triaged requests for same day appointments and provided advice or arranged for that patient to be seen by a GP or nurse. Patient feedback regarding the triage service was generally very positive.
- The practice offered an extended hours' commuter surgery on one morning each week, and provided one Saturday morning clinic each month.
- The practice hosted some services on site including ante-natal care, and a weekly Citizens Advice Bureau session. This made it easier for their patients to access services locally.
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The premises were well-maintained and clean, and were well-equipped to treat patients to meet their needs. The practice accommodated the needs of patients with disabilities, including access to the building through automatic doors.
- The practice worked with other local practices to provide primary care services to temporary patients due to the high number of visitors to this popular tourist area within the Peak District National Park.
- Information about how to complain was available. Learning from complaints was shared with staff to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they were offered a private room to ensure their privacy.

Are services well-led?

Good

- The partners had a strong commitment to delivering high quality care and promoting good outcomes for patients.
- There was a clear staffing structure in place. GP partners had lead roles providing a source of support and expert advice for their colleagues

Summary of findings

- The partners worked collaboratively other GP practices in their locality, and worked proactively with their CCG.
- The partners reviewed comparative data provided by their CCG and ensured actions were implemented to address any areas of outlying performance.
- Staff felt well-supported by management, and the practice held regular staff meetings. An annual 'away day' team building event contributed to an effective and motivated workforce.
- The practice had developed a wide range of policies and procedures to govern activity.
- The practice proactively sought feedback from patients, which it acted on to improve service delivery. The practice had an active Patient Participation Group (PPG). This group worked well with the practice, and made suggestions to improve services for patients.
- The practice used innovative measures to shape service delivery, and we saw a number of initiatives that had influenced positively upon patient care. For example, the piloting of dementia support workers within a GP practice setting.

Summary of findings

The six population groups and what we found

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

Older people

Good

- The practice had been involved in an enhanced access pilot scheme for those with a deteriorating illness. This gave the practice direct access to the physician for older age patients for telephone advice; and access to an urgent outpatient review, rather than admitting the patient to hospital.
- The practice team worked closely with a community matron and care co-ordinator to plan and oversee the management of their most vulnerable patients, including those who were at risk of a hospital admission. This was enhanced further by weekly meetings attended by health and care professional staff from the wider health, social and voluntary communities, to plan and co-ordinate care to meet their patients' needs.
- Care plans were in place to identify individual patient need, and summary records were shared with relevant services to ensure the patient received the right care at the right time.
- Longer appointment times could be arranged for those patients with complex care needs, and home visits were available for those unable to attend the surgery.
- The practice provided care for residents at two local care homes, and fortnightly visits were undertaken to each home by a practice nurse. Any urgent requests for a consultation were undertaken within 24 hours by a GP.
- The practice shared the medical cover provided to a ward at a local residential unit with another local GP surgery, and visited these patients twice each week.
- Uptake of the flu vaccination for patients aged over 65 was 71%, which was in line with local (73.9%) and national (70.5%) averages.

People with long term conditions

Good

- The practice undertook annual reviews for patients on their long-term conditions registers. The recall system had recently been restructured in response to comparatively lower QOF attainment, and this had impacted positively on outcomes.
- QOF achievement for 2014-15 for conditions including asthma, hypertension and dementia were below the CCG and national averages. However, the practice was able to explain the lower achievement and had developed actions to enhance their performance. We observed practice data (subject to external verification) that demonstrated performance was improving.

Summary of findings

- There was a lead designated GP and/or nurse for all the clinical domains within QOF.
- The practice had developed an 'expert patient' programme to support patients following the diagnosis of a new condition. This enabled patients to talk to someone with personal experience of living with a particular condition, and to discuss any issues or concerns from a non-medical perspective.

Families, children and young people

Good

- The GPs held a weekly baby clinic on site. Dual appointments were provided for post-natal reviews and eight-week baby checks as a 'one-stop shop' for new parents.
- The midwife held an ante-natal clinic on site every week.
- Childhood immunisation rates were generally in line with local averages. For example, rates for the vaccinations given to children at five years of age ranged from 93.2% to 98.6% (local average 96.5% to 99.1%). Appointments for vaccinations were extended to 20 minutes to ensure the accuracy of the procedure, and also to allow time for parents to ask any questions.
- The health visitor attended a meeting with the lead GP for child safeguarding once a month to discuss any concerns. Child protection alerts were used on the clinical system to ensure clinicians were able to actively monitor any concerns. Arrangements to follow up on children who failed to attend for hospital appointments required strengthening.
- Appointments for children were available outside of school hours.
- There was a notice board in the waiting area dedicated to younger person's health. In addition, a practice leaflet was available providing information on services which young people may wish to access confidentially such as healthy eating, drug use, and bullying.
- Family planning services were provided to fit and remove intrauterine devices (coils) and implants, and advice and support was available for all aspects of contraception.
- The practice worked within their local community to promote health – for example, representatives had attended a local nursery to discuss health matters.
- The practice had baby changing facilities, and welcomed mothers who wished to breastfeed on site.

Summary of findings

Working age people (including those recently retired and students)

Good

- The practice offered on-line booking for appointments and requests for repeat prescriptions. The practice provided electronic prescribing so that patients on repeat medicines could collect them directly from their preferred pharmacy.
- Extended hours' GP and nurse consultations were available. Early morning appointments were available one day each week to accommodate the needs of working people. Additionally, appointments to see a GP or the nurse were available on one Saturday morning each month.
- Telephone consultations were available each day, meaning that patients did not have to travel to the practice unnecessarily.
- The practice promoted health screening programmes to keep patients safe. Although performance for cervical and breast screening was slightly lower than average figures, the practice was able to explain this and describe how this was being addressed.
- The practice offered a flexible approach towards health checks and any patient could request to have one undertaken.
- The practice had attended the local university's 'Freshers' Fair', to provide advice and support on younger people's health, and to ensure that students knew how to access local primary care services.

People whose circumstances may make them vulnerable

Good

- The practice was mindful that their catchment area incorporated pockets of community deprivation. They had been supportive of a local Sure Start scheme (aimed at giving children the best possible start in life) that had recently closed; however, the practice continued to provide high levels of support to this population in recognition of their health needs.
- The practice had undertaken an annual health review in the last 12 months for 48.6% of patients with a learning disability However, a manual check of records by the practice team demonstrated this figure was 84%, indicating that there may be an issue with coding.
- Longer appointments and home visits were available for vulnerable patients, and same day access to a GP was provided for any vulnerable patients with acute needs. The practice encouraged concerned relatives or support workers to contact the practice on the patient's behalf. Failed attendance was used an opportunity to look into the reasons behind this, and to educate the patient or manage their situation differently.

Summary of findings

- There was a designated lead GP for palliative care. Patients with end-of-life care needs were reviewed either at weekly multi-disciplinary team meetings, or at designated monthly palliative care meetings. These patients had supporting care plans in place. Community based staff informed us that the GPs were caring and highly responsive to these patients, and ensured that any needs were acted upon promptly.
- The practice supported homeless patients to register at the practice. Residents at a local women's refuge were encouraged to register with the practice.
- Staff had received adult safeguarding training and were aware how to report any concerns relating to vulnerable patients. There was a designated lead GP for adult safeguarding.

People experiencing poor mental health (including people with dementia)

Good

- The practice achieved 85.4% for mental health related indicators in QOF, which was 12.7% below the CCG and 7.4% below the national averages. Exception reporting rates for mental health were higher at 22.5% (local 14.5%; national 11.1%) although the practice were able to explain the reasons for this.
- 91.8% of patients with poor mental health had a documented care plan during 2014-15. This was marginally below the CCG average by 1.4%, and 3.3% higher than the national average, although exception reporting rates were higher.
- Access to counselling and associated talking therapies was available by GP or self-referral. Patients could attend these services in the local area.
- The practice lead GP for mental health was also the CCG's designated clinical lead for mental health.
- The practice had established strong links with local mental health care teams. A community psychiatric nurse (CPN) attended multi-disciplinary meetings to review and discuss any patients with ongoing mental health needs.
- Appointments were available on the day for patients experiencing acute mental health difficulties. This was facilitated via the senior clinician triage system.
- 91% of people diagnosed with dementia had had their care reviewed in a face-to-face meeting in the last 12 months. This was above local and national averages by approximately 7%, with comparable exception reporting rates.

Summary of findings

- The practice staff had received training from the Alzheimer's Society to become 'Dementia Friends'. This had involved the PPG who had reviewed patient-facing issues such as improved signage further to the training. Reception rang patients with dementia to remind them of their upcoming appointment.
- The practice used self-management techniques to improve anxiety management.
- The practice provided care to 20 patients in local home, 12 of whom were included on the practice dementia register. The practice dealt with individual patient needs as required, but were in the process of working to review future arrangements.
- The practice worked with local charity projects that promoted well-being and support for people with mental health difficulties.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016, and the results showed the practice was generally performing in line with local and national averages. A total of 233 survey forms were distributed and 115 of these were returned, which was a 49% completion rate of those invited to participate.

- 96% of patients found the receptionists at this surgery helpful compared against a CCG average of 89% and a national average of 87%.
- 73% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 71% and a national average of 65%.
- 93% of patients said they would recommend this surgery to someone new to the area compared to a CCG average of 84% and the national average of 78%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received nine comment cards which were all extremely positive in respect of the level of care provided and the interactions with the practice team. Patients said they were treated in a respectful manner and that they had confidence in staff who they considered to be knowledgeable and focused upon their individual needs. Patients commented that the whole practice team were approachable, helpful and caring.

All of the 14 patients we spoke with during the inspection reported a high level of satisfaction regarding their consultations, stating that they were provided with sufficient consultation time and that they felt treated as individuals. Patients provided personal examples of positive interactions with practice staff, and good experiences regarding their attendance at the surgery.

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Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Stewart Medical Centre

Stewart Medical Centre provides care to approximately 9,642 patients in Buxton, a town situated in the High Peak area of North Derbyshire. The practice provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The site operates from a purpose built two-storey detached building constructed in 1991, which has housed the practice for the last 15 years.

The practice is run by a partnership of two male GPs and the partners employ five female salaried GPs. The practice also hosts a retained GP. This is a part-time GP working to retain their skills and to keep up to date with the view of returning to NHS general practice in the future. Further to a recent successful teaching practice accreditation visit, the surgery were to host year 2 foundation doctors from August 2016. These are qualified doctors undertaking a two-year training programme before choosing to work as a GP or within a hospital specialty.

The nursing team comprises of four practice nurses, three of whom are able to prescribe specific medicines. The fourth practice nurse is designated as a treatment room nurse, and the practice also employ a health care assistant. The clinical team is supported by a business manager and an operations manager, with a team of 12 administrative and reception staff. The practice employs two cleaning staff.

In addition, the practice currently hosts two dementia support workers as part of a pilot scheme to enhance care and support for patients with dementia and their carers.

The practice age profile is mostly comparable to national figures, although it has slightly lower percentages of patients aged 25-40. The registered patient population are predominantly of white British background, and the practice is ranked in the fourth lowest decile for deprivation status. Whilst predominantly sited in an area of relatively high affluence, the practice also serves one of the most deprived wards within the county.

The practice opens daily from 8am until 6.30pm.Extended hours opening operates every Wednesday morning when the practice opens from 7am. Additionally, the practice provides a weekend surgery on the third Saturday of every month when the practice is open between 8am and 12.15. The practice closes one Wednesday afternoon each month for staff training.

Scheduled GP morning appointments times are usually available from approximately 8.10am until 12.30am. Afternoon GP surgeries run approximately from 3.10pm to 6pm. On the monthly Saturday session, two GPs are available for consultations between 8.10am to 10.50am. Two nurses are on duty for the Saturday clinics and will see patients between 8am and 11.45am. Appointments are available from 7am every Wednesday morning to see a GP or a nurse.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed, patients with urgent needs are directed via the 111 service

to a locally based out-of-hours and minor injuries unit in Buxton operated by Derbyshire Health United (DHU). This opens from 6.30pm to 10.30pm each weekday, and from 9.30am until 10.30pm at weekends and bank holidays. The nearest Accident and Emergency (A&E) unit is based in Stockport.

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

We carried out an announced inspection on 1 August 2016 and during our inspection:

- We spoke with staff including GPs, the business manager, the operations manager, members of the nursing team and reception and administrative staff. In addition, we spoke with representatives from two local care homes, a community matron and care co-ordinator, and the CCG pharmacist working at the practice regarding their experience of working with the practice team. We also spoke with 14 patients who used the service, and the chair of the practice's patient participation group.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed nine comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a procedure in place for reporting and recording significant events, and the practice encouraged staff to report incidents within a supportive 'no blame' culture. This resulted in a relatively high number of reported significant events over the last 12 months.

- A significant event reporting form was provided for staff, although this was not available electronically, but the system for recording the details of the investigation and learning from events could be strengthened to provide a clear audit trail
- The practice discussed incidents at either clinical or general staff meetings which were held monthly, and those with wider learning were shared across all staff groups. We saw that notes were recorded from the event meetings and these provided evidenced that learning had been applied.
- Some complaints were reviewed via the incident reporting process to consider any shared learning that may apply. Positive events were also included to ensure good practice was highlighted and shared.
- People received support and an apology when there had been unintended or unexpected safety incidents. We were provided with an example of this following an error within the child immunisation programme. In order to deal with this issue more sensitively, the practice initially rang those parents affected to explain the content of a letter they would receive about the incident. They also reassured them that the error did not have any adverse effect on the child's health. Parents were invited into the practice to explain the event and were told about the actions taken to prevent the same thing happening again. Appointments for vaccinations were extended to 20 minutes to ensure the accuracy of the procedure, and to allow time for parents to ask any questions.

The practice had a process to review alerts received including those from the Medicines Health and Regulatory Authority (MHRA). When concerns were raised about specific medicines, patient searches were undertaken to identify which patients may be affected. Effective action was then taken by clinicians to ensure patients were safe, for example, by reviewing their prescribed medicines.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local guidance and policies were accessible to staff. Practice safeguarding policies were accessible and up-to-date, and alerts were used on the patient record to identify any vulnerable children. GPs had access to key safeguarding contact information as an application on their mobile phones. There was a lead GP for safeguarding both children and adults, who had received training at the appropriate level in support of the role. The health visitor attended a monthly meeting with the lead GP to discuss any child safeguarding concerns. Minutes were produced from these meetings, and we observed that these were extremely well-documented. An entry was made within the patient record to highlight that the case had been reviewed at the meeting, and the minutes were available for other clinicians to access on the practice electronic system. Practice staff demonstrated they understood their responsibilities and all had received training relevant to their role, and the lead GP was able to provide an example of where action had been instigated to protect a child's welfare. However, the practice needed to ensure that records clearly documented the follow-up actions taken with children who could be vulnerable, and had not attended a hospital appointment.
- A notice in the reception and the consulting rooms advised patients that a chaperone was available for examinations upon request. The practice booklet also contained this information. Members of the reception team and the Business Manager had undertaken training in support of this role, providing access to either a male or a female chaperone. Staff who undertook chaperoning duties had received a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). A practice chaperone policy was available.
- We observed that the practice was tidy and maintained to good standards of cleanliness and hygiene. A practice nurse was the appointed infection control lead. Links had been established with the local community

infection control and prevention team. There were infection control policies in place, which had been reviewed regularly. Practice staff had received infection control training and received information as part of new staff inductions. A handwashing audit was being arranged for the practice team. Infection control audits were undertaken regularly, and we saw evidence that actions had been undertaken in response to the findings. The practice employed two cleaners and a written schedule of cleaning tasks was available. A schedule of deep-cleaning was undertaken by the cleaning team on most Saturdays.

- We reviewed three staff files and a locum GP file and found that the necessary recruitment checks had been undertaken prior to commencing work with the practice. For example, proof of identification, qualifications, registration with the relevant professional body and the appropriate checks through the DBS.
- The practice had a robust system to manage incoming correspondence to ensure that any actions, such as a change to a patient's medicines, were completed promptly. Staff understood the process in place and we saw that correspondence was up to date on the day of our inspection.

Medicines management

- The arrangements for managing medicines in the practice, including emergency medicines and vaccinations, kept patients safe. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Regular medicines stock checks including expiry dates were undertaken and we saw documented evidence of this. 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. Nurse prescribers received support and mentorship from a designated GP prescribing lead.
- There was evidence in place to support that the practice reviewed those patients who had been prescribed high-risk medicines and there was monitoring in place to ensure prescribing remained safe. The system needed to be strengthened to ensure reviews were always undertaken within the recommended timescales as a small number fell slightly outside of these.
- There were processes to follow up any patients who had not collected prescriptions.

Monitoring risks to patients and staff

- There was a health and safety policy available, and the practice fulfilled their legal duty to display the Health and Safety Executive's approved law poster in a prominent position.
- The Business Manager had completed a variety of risk assessments to proactively manage any new or emerging risk areas. Documentation was also available for the control of substances hazardous to health.
- The practice had undertaken a generic risk assessment related to fire safety, although there was no specific documentation to support a recent comprehensive inspection of the building. Fire alarms and extinguishers were serviced regularly to ensure they were in full working order. Staff had received regular fire training, and the practice had undertaken annual evacuations to ensure staff were aware of the procedure to follow in the event of a fire.
- All electrical equipment was regularly inspected to ensure it was safe to use, and medical equipment was calibrated and checked to ensure it was working effectively. We saw certification that this had been completed by external contractors in the last 12 months.
- A formal risk assessment for legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings) had been completed and an action plan was in place in support of ongoing monitoring and control measures.
- There were arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. This included a structured programme for annual leave arrangements, and a minimum staffing quota.

Arrangements to deal with emergencies and major incidents

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

- Staff had received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. The practice kept a spare battery for the defibrillator and kept three oxygen cylinders as a contingency measure.

Good

Are services safe?

- 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 were systems in place to alert staff to assist rapidly with any emergency situation, such as if a patient were to collapse.
- A first aid kit and accident book were available.
- The practice had a business continuity plan for major incidents such as power failure or building damage. Copies of the plan were kept off site in case any incidents made entry to the site inaccessible, and alternative locations had been considered as a contingency to provide temporary accommodation. The plan was reviewed regularly with the most recent update in May 2016.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, and local guidance, for example, in relation to prescribing.

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 87% of the total number of points available. Exception reporting rates at 11.5% were generally in line with local and national averages of 11% and 9.2% respectively. Exception reporting is the removal of patients from QOF calculations where, for example, a patient repeatedly fails to attend for a review appointment.

QOF data from 2014-15 showed:

- Performance for diabetes related indicators was 85.5% which was below the CCG average of 96.7% and national average of 89.2%. The practice was taking actions to enhance performance, for example in relation to higher blood pressure associated with diabetes. Exception reporting for these indicators at 15.6% was slightly above the CCG average of 13.4%, and above the national average of 10.8%.
- 70% of patients with hypertension had regular blood pressure tests, which was below the CCG average of 85%, and the national average of 84%. The practice had targeted this area and were making some progress. We were provided with practice data (as yet unverified) that demonstrated an increase to 73% for 2015-16.
- QOF achievement for 2014-15 for asthma was 44.6% which was significantly below the CCG average of 97.6%, and the national average of 97.4%, although exception reporting rates were much lower.
- The practice achieved 99.1% for indicators related to atrial fibrillation (an irregular heart rate). This was in line with local and national averages.

The practice was able to explain the lower achievement in areas such as asthma and hypertension due to a number of staff changes within their clinical team. Some new staff had needed to undertake additional training in support of this role. In addition, the practice had held QOF meetings to discuss and plan actions to enhance performance; a new recall system had been instigated; and new equipment had been purchased. Clinicians were also designated lead areas of responsibility for QOF. Practice held data, which had not yet been verified, demonstrated that the measures had improved QOF achievement. For example, the overall achievement for asthma had risen from 44.6% to over 70%.

The practice was able to provide rationale for some relatively higher rates of exception reporting for specific clinical domains. For example, mental health indicators had exception reporting rates at 22.5% (14.5% locally and 11% nationally), although this only accounted for approximately 17 patients in total. The practice demonstrated that the reporting was compliant with national rules. They also identified that further to the retirement of key staff members, the valued rapport and trust which had been established with the clinician now needed to be re-established with new members of the team.

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

- We saw evidence of an active programme of audit including four completed full-cycle clinical audits undertaken in the last year, where changes had been implemented and monitored with positive outcomes for patients. We reviewed a full cycle audit on atrial fibrillation completed in 2016. Whilst the practice was already performing highly in this area, the second audit demonstrated an increase from 92% to 94% of patients with atrial fibrillation being assessed regarding their suitability for anticoagulation therapy.
- The practice participated in local benchmarking activities. For example, they participated in bi-annual quality focussed visits with the CCG to review comparative data including referral rates and hospital admissions.

Effective staffing

- The practice provided an induction programme for all newly appointed staff, although documentary evidence of this was brief and unsigned. The induction

incorporated shadowing opportunities and access to support from colleagues where appropriate. A pack was available for locum GPs containing key information on the practice and local procedures to help to support them in their roles.

- The practice ensured role-specific training with updates was undertaken for relevant staff e.g. administering vaccinations and taking samples for the cervical screening programme.
- Staff had received an annual appraisal and we saw documentation that evidenced this. We spoke to members of the team who informed us of how learning opportunities had been discussed during the appraisal and supported by the practice. For example, a nurse was supported by the practice to complete a nurse prescribing course and an honours degree in long-term conditions.
- Staff received mandatory training that included safeguarding, fire safety awareness, and basic life support. Staff had access to and made use of e-learning training modules and in-house training. The practice had protected learning time on one afternoon each month when in-house training was arranged for the practice team. GPs attended training events organised by their CCG on some of these months. The practice also held occasional lunchtime meetings to discuss clinical updates.
- Nurses received support in their roles, and to prepare for revalidation. For example, the nurses who prescribed were able to access support from GPs in relation to their prescribing role. Practice nurse meetings were held each month.
- The practice worked closely with the CCG pharmacist who attended the practice throughout the week. The pharmacist assisted the practice with all medicines-related issues and provided expert advice to the practice's clinical team.

Coordinating patient care and information sharing.

- The information needed to plan and deliver care and treatment was available to clinicians in a timely and accessible way through the practice's electronic patient record system. This included care plans, medical records, and investigation and test results.
- The practice team worked collaboratively with other health and social care professionals to assess the range and complexity of patients' needs, and plan ongoing care and treatment. Weekly multi-disciplinary meetings were held between practice clinicians and representatives from a wide range of professionals. This included the community matron, the care co-ordinator, district nurses, social services, the community psychiatric nurse; and others (for example, a psychiatrist) as required to discuss particular cases. The meetings focused upon vulnerable patients including those at high risk of hospital admission.
- Monthly multi-disciplinary meetings involving a lead GP, district nurses and the community matron were held to review patients on the practice's palliative care register. This might also include representation from the Macmillan team and local hospice, when appropriate. This ensured patients with end of life needs and their carers received the support they required. A code was placed on each patient's electronic record to indicate that a discussion had been held at this meeting. The lead GP took handwritten notes which were kept in a secure location for other clinicians to access if they so required.
- Clinical staff met together informally at the end of each morning session, offering an opportunity to share information, and to resolve any issues that had arisen that day. A formal clinical meeting involving GPs, nursing staff and practice management was held each month. This took place on different days so that all part-time staff had the opportunity to attend the meetings periodically.

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 followed national guidelines to assist clinicians in deciding whether or not to give sexual health advice to young people without parental consent.

Supporting patients to live healthier lives

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

Good

Are services effective?

(for example, treatment is effective)

- The practice referred relevant patients for advice on healthier lifestyles, including services to help patients stop smoking and to control alcohol intake. Representatives from the alcohol support service periodically arranged to see patients within the practice.
- The practice provided personalised and bespoke health checks for any patients requesting to have one. All new patients registering with the practice were also offered a health check. Appropriate follow-up on the outcome of any health assessments was taken where abnormalities or risk factors were identified.
- Uptake for the cervical screening programme was 78.8%, which was slightly below the local CCG average of 84.1%, and national average of 81.8%. However, the practice had lower exception reporting rates at 1.8% (CCG 2.9%; national 6%). National screening programme data showed the uptake for bowel screening was generally in line with local and national averages, but breast screening was lower than local averages.
- Childhood immunisation rates for the vaccinations given to children aged up to five years of age were in line with averages. The overall childhood immunisation rates for the vaccinations given to under two year olds ranged from 95.3% to 100% (local average 95.2% to 98.9%) and five year olds from 93.2% to 98.6% (local average 96.5% to 99.1%).

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

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

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

- 91% of patients said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 90% of patients said the last GP they spoke to was good at treating them with care and concern compared to a CCG average of 90%, and the national average of 85%.

We spoke to some members of the local community health provider team and care home staff who reported that the GPs were patient-centred, approachable and respectful of their opinions.

Care planning and involvement in decisions about care and treatment

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

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

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 86%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87%, and the national average of 82%.

Patient and carer support to cope emotionally with care and treatment

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

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

The practice had identified 1.3% of the practice list as carers, and identified new carers upon registration. The practice had identified a staff member to become a designated 'Carers' Champion'. There were some links with local carers association, although the practice was aware that their approach needed to be more specific to carers' needs. For example, they would be offering vaccinations to all carers during the next flu campaign, and planned to invite a carers' association representative to the next flu clinic.

The practice had developed an expert patient programme. This enabled patients with a new diagnosis to be able to speak with another patient with personal experience of dealing with the same condition. The practice provided an example of how a patient had been supported to attend a two-week cancer referral after talking to an expert patient for advice and reassurance.

The practice worked to high quality standards for end of life care to ensure that patient wishes were clear, and that they were involved in the planning of their own care. GPs would usually contact relatives by telephone following a patient death, and would visit them if required. Information was provided to signpost carers to appropriate services such as

Good

Are services caring?

counselling where indicated. One of the returned comment cards stated how the practice had provided dignified, respectful and responsive care for a patient with dementia at the end of their life. The practice undertook a review of patient deaths to consider any learning points for the future.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG), to secure improvements to services where these were identified. For example, the practice had submitted a successful funding bid to pilot two dementia support workers within primary care. The dementia workers covered all three GP practices in the Buxton area to ensure an equitable service was provided for patients and their carers.
- Patients could order repeat prescriptions on line. The practice participated in the electronic prescription service, enabling patients to collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- All of the consulting rooms were accessed on the ground floor. The site was accessible for patients with reduced mobility, and access to a hearing loop system within reception and the consulting rooms was provided for patients with a hearing impairment.
- The practice provided services to ensure these were easily accessible for their patients. This included 24 hour blood pressure monitoring; ECGs (a test of the heart's rhythm); spirometry (a test to assess breathing); travel vaccinations; and performed some minor operations (including joint injections and removal of asymptomatic benign skin lesions). The GPs held a weekly baby clinic on site. Dual appointments were provided for post-natal reviews and eight-week baby checks as a 'one-stop shop' for new parents.
- The practice offered a more accessible and flexible approach to health checks which were available to all practice patients.
- The practice offered a full range of family planning and genitourinary (GUM) services on site. One of the GPs was on the specialist register for sexual health and saw a number of patients who would otherwise be referred into secondary care. The practice provided a full sexually transmitted infection (STI) service including screening for HIV, syphilis and herpes, and offered basic contact tracing for their patients.
- Blood tests were not routinely performed within the practice, apart from on an urgent basis. There were three local venues where patients could book a routine blood test.
- The waiting area contained a good range of information on services and support groups. Health promotion material was clearly displayed.
- A touch screen log in facility was available for patients to book in upon arrival at the surgery. A television screen displayed information for patients in the waiting area.
- Patients could be moved into a private room besides the reception for private discussions.
- The practice had established social media accounts which provided surgery updates and health promotion information.
- The practice hosted some services on site to facilitate better access for patients. This included ante-natal clinics with the midwife; and a weekly Citizens Advice Bureau session. Staff from alcohol support services and the mental health crisis team would occasionally arrange to see people within the practice. The building was being used to capacity and therefore did not have the scope to offer more services on site. However, other services such as access to psychological therapies were available at local venues.
- Same day appointments were available for children and those patients with medical problems that required them to be seen urgently. Longer appointments could be booked for those patients with more complex needs. Home visits were available for older patients and others with appropriate clinical needs which resulted in difficulty attending the practice.
- The practice provided care for residents at two local care homes. A practice nurse routinely visited each home on a fortnightly basis to review patients, and GPs responded to any urgent requirements which arose. We spoke to a representative from one home and received a written statement from the other home. Both expressed they were highly satisfied with the service they received. They commented that the regular nurse visits had reduced the number of GP visit requests and had reduced the number of hospital admissions for their patients, although no data was available to support this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice worked with other local practices on a monthly rota to provide primary care services to temporary residents due to the high number of visitors to the Peak District. Links had been established with the local Minor Injuries Unit to facilitate this process.
- The surgery produced a patient newsletter to provide updates about the practice, and information on services. The practice website was up to date and acted as a useful source of information for patients.
- Translation services were available for patients whose first language was not English.

Access to the service

The practice opened daily from 8am until 6.30pm.Extended hours opening was available every Wednesday morning from 7am. The practice also provided a weekend surgery on the third Saturday of every month when the practice opened between 8am and 12.15. The practice closed one Wednesday afternoon each month for staff training.

Scheduled GP morning appointments times were available from 8.10am until12.30am. Afternoon GP surgeries ran approximately from 3.10pm to 6pm. On the monthly Saturday session, two GPs were available for consultations between 8.10am to 10.50am. Two nurses were on duty for the Saturday clinics and saw patients between 8am and 11.45am.

Patients could book appointments on line. Requests for same day appointments were triaged by a duty GP. The GP would ring patients and provide advice on the management of their condition, or arrange for them to be seen at the surgery by either a GP or nurse. Appointments for 48-72 hour access were made available daily and could be booked further to telephone triage with the GP.

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

- 87% of patients found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 92% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 88% and a national average of 85%.
- 87% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 55% of patients usually got to see or speak to their preferred GP, compared to the CCG average of 60% and national average of 59%.

Staff informed us that patients could book ahead up to five weeks in advance to see a GP. On the day of our inspection, we saw that the next available routine GP appointment was available in three days' time. We were informed that the usually waiting time for a routine appointment was between one and two weeks. Ongoing monitoring of capacity and demand was in place and action was taken as appropriate to respond to this – for example, additional GP sessions or the use of a locum GP. The majority of patients we spoke with on the day, and feedback received on a number of comment cards, generally expressed satisfaction with the appointment system. Patients said they could usually obtain an appointment on the day when they needed one, and found that the triage system worked well.

Listening and learning from concerns and complaints

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

- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The business and operation managers in the practice were the designated people that co-ordinated the complaints process. Clinicians always reviewed any complaints of a clinical nature.
- We saw that information was available to help patients understand the complaints system in the waiting area.

We looked at a selection of complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. The practice offered to meet with complainants to discuss their concerns whenever appropriate. Complaints were considered at the weekly partners meeting, and some were used as part of a significant event analysis review. The practice involved their PPG in reviewing complaints. Lessons were learnt and shared with the team following concerns and complaints, and action was taken to as a result to improve the quality of care. For example, the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice had agreed to document when appointments had been offered but declined by patients to evidence that patients could have been seen at an earlier date to instigate an effective treatment plan.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The service had set aims and clear objectives.
- The practice held a partners' meeting each week with the practice management. This reviewed key issues relating to the practice business, and notes from the discussions were documented. In addition, the partners and practice management held an annual meeting focused upon strategic issues. This provided an opportunity to discuss future planning arrangements such as succession planning, premises issues, or developments such as re-establishing GP training practice status. The partners had canvassed feedback from the salaried GPs and nurses to inform their business meeting discussions. This demonstrated an inclusive approach in identifying and resolving issues. For example, more administrative time had been allocated to clinicians, and additional nursing support had been arranged to support the on call GP.
- Whilst the practice did not have a written business plan, the partners and management had a clear vision for the future which they were able to articulate during our inspection.
- The practice worked collaboratively with two other practices in the Buxton area including a joint quarterly meeting. The practice was also part of a GP federation, although this was not particularly active at the time of our inspection.

Governance arrangements

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

- There was a clear team structure in place, and staff were aware of their own roles and responsibilities. GP partners had defined lead areas of responsibility, and acted as an expert resource for their colleagues. A salaried GP was the designated practice prescribing lead.
- Systems were in place for identifying, recording and managing risk, and implementing mitigating actions.
- A wide range of practice specific policies were implemented and were available to all staff.
- An understanding of the performance of the practice was maintained which included the analysis and benchmarking of QOF performance, and referral and prescribing data. Actions were undertaken when any variances were identified.
- The practice had received the Royal College of General Practitioner's Quality Practice Award in 2012 in recognition of high qualitypatient careby all members of staff.

Leadership and culture

- The practice had undergone significant staffing changes in 2013 which led to changes within the partnership and the skill mix in place. This was a difficult period for the practice but was successfully managed without impacting upon patient care. There were plans for another GP to join the partnership shortly, and the practice was proactively planning for the future.
- The partners engaged with their CCG and worked with them to enhance patient care and experience. One GP partner was the lead GP for mental across the CCG, and the other partner was the chair of the clinical governance group for the locality. Another GP attended the Primary Care Development Group as the representative for the High Peak GP practices. The practice manager attended the local practice managers' meetings.
- The partners and practice management demonstrated they had the experience and capability to run the practice effectively to ensure high quality care.
- Staff told us there was an open culture within the practice and said the partners and practice management were approachable, and always took the time to listen to all members of staff. Staff said they felt respected, valued and supported by the partners and managers in the practice. For example, payment was always offered when staff had worked in excess of their contracted hours.
- Staff told us the practice held monthly practice team meetings, and that they had the opportunity to raise any issues at these meetings and felt confident and supported in doing so. The meetings were held when the practice closed for training on one afternoon each month. Minutes of this meeting were documented.
- Staff we spoke with told us that the practice was a good place to work, and the team supported each other to complete tasks. Each year, staff participated in an annual team building event which most recently been

Are services well-led?

Good

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

undertaken as a raft building exercise. Social events took place periodically which supported a strong team spirit within the practice. Members of the attached practice team were also included and a selection of these staff told us they were always included and welcomed by the practice team.

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

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

- The practice had gathered feedback from patients through patient surveys and on the NHS Choices website; via complaints received; a suggestion box; and responses received as part of the Families and Friends Test (FFT). The FFT is a simple feedback card introduced in 2013 to assess how satisfied patients are with the care they received. The practice collated FFT feedback and provided feedback to patients which was displayed in the reception and on the practice website.
- The PPG met quarterly, and had a core membership of people who regularly attended meetings. In addition, there was a wider virtual network which communicated by email and post. Practice management would attend these meetings, and a GP representative would also often attend. There was a designated display board for the PPG within the main waiting area. This focused on recruitment of new members rather than highlighting the PPG's achievements. The PPG had designed patient surveys and analysed these jointly with the practice. This led to the creation of an action plan designed to improve patient experience. The PPG influenced developments within the practice. For example, a folder containing key patient information was available in the reception area. This included guidance developed by the PPG to book an appointment for a blood test online with clear instructions and screenshots.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

- The practice had submitted a successful funding request to pilot two dementia support workers within primary care. Their objective was to offer additional support or provide guidance to non-complex patients and their carers, in the early stages of their condition or in those still coping well with some low-level memory or cognitive problems. The workers had initially focused upon patients being cared for at home, but would also be reviewing other patients living in residential or nursing care.

An example of a positive outcome had been where the dementia support workers had encountered a patient with compliance issues in taking their prescribed medicines. The support workers consequently organised care calls with medicines prompts to ensure the patient remained safe by taking their medicines as required**.** The practice dementia diagnosis rate had improved with the support workers in post by in excess of 20% from 71 to 86 cases.

The dementia workers covered all three GP practices in the Buxton area to ensure an equitable service was provided locally for patients and their carers. The pilot scheme was to be formally evaluated to assess outcomes for patients, and was aligned to the University of Nottingham who would be undertaking the final evaluation, including reductions in hospital admissions; reductions in hospital stays; reduced requirements for continuing care; and improved rates of patients dying in their preferred location.

- The practice had been involved in an enhanced access pilot scheme with the hospital provider at Stockport for those with a deteriorating illness. This gave the practice direct access to the physician for older age patients for telephone advice, or access to an urgent outpatient review, rather than admitting the patient to hospital.
- Stockport was chosen as one of 50 areas nationally to try out this new way of providing services in 2015 and was named a 'Vanguard' site by NHS England. Stewart Medical Centre was the only one of the three GP practices in Buxton to participate in this scheme. The High Peak Locality group chaired by one of the GP partners had recently been in talks with the CCG and agreed a fully commissioned service providing rapid telephone access to consultants in eight specialities at Stockport, for all GP's in the High Peak area. This was successful in terms of quality of care; ease of access; admissions avoidance; and reductions in outpatient clinic referrals.