# Buxton Medical Practice

## Quality Report

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Buxton Medical Practice on 27 October 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, and appropriately reviewed. Learning was applied from events to enhance future service delivery.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. This was kept under review by the practice which proactively used audit as a way of ensuring that patients received safe and effective care.
- Risks to patients were assessed and well managed. Regular liaison meetings were held with the wider multi-disciplinary team to co-ordinate the provision of effective and responsive care. There was good evidence of collaborative working including end of life care and safeguarding. The CCG pharmacist attached to the practice provided regular and effective support on medication issues.
- All members of the practice team had received an annual appraisal and had undertaken training appropriate to their roles, with any further training needs identified and supported by the practice.
- Results from the national GP survey, and responses to our conversations with patients showed that patients were treated with compassion, dignity and respect, and that they were involved in their care and decisions about their treatment.
- The practice worked closely with other services and organisations in the locality, and across the CCG area to plan and review how services were provided to ensure that they met people's needs.

# Summary of findings

- Urgent appointments were available on the day they were requested. However, patients said that they sometimes had to wait a long time for non-urgent appointments.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from patients, which it acted upon. For example, the practice undertook patient surveys and encouraged ongoing feedback via the use of a suggestion box. The practice implemented changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG). For example, the practice had automatic entrance doors which had been raised as an issue by the PPG.
- The practice had introduced the role of advanced nurse practitioners (ANPs) as a response to challenges with GP recruitment and to ensure a wider skill mix to give more flexibility in how services were delivered.

However there were areas of practice where the provider should make improvements.

Importantly the provider should:

- Implement a review of the practice's cleaning schedules to incorporate all areas used by patients.
- Implement a review of the storage and management of paper prescriptions in the practice.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Incidents were reviewed by the partners and practice management team and any lessons learnt were communicated to the team in order to support improvement.

The practice had established effective systems to manage and review safeguarding concerns including regular meetings with the health visiting team.

The appointment of new staff was supported by appropriate recruitment checks and all of the practice staff had received clearance from the Disclosure and Barring Service (DBS).

Risks to patients were assessed and well managed. Risk management was comprehensive, up to date, and supported by well documented risk assessments including fire, and health and safety. Follow up actions had been completed following assessment, and risk areas were kept under review by the partners and management team at their meetings.

Procedures for dealing with medical emergencies were robust. Staffing levels were maintained to keep patients safe. Administrative systems were responsive and ensured that incoming correspondence was dealt with in a timely and effective manner.

We found that the practice's cleaning schedule was not inclusive of all the areas accessed by patients. Stocks of paper prescriptions should be reviewed to remove excess stock and also ensure a traceable system was in place for the supply of scripts delivered to the practice.

**Are services effective?**

Good

The practice is rated as good for providing effective services.

Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines, and that clinicians used these as part of their work. Regular audits were undertaken and improvements were made as a result to enhance patient care. For example, an audit of patients with atrial fibrillation (a risk factor for stroke associated with clot formation) resulted in two patients being commenced on appropriate anticoagulation therapy in line with 2014 NICE guidance.

# Summary of findings

Data showed patient outcomes were at or above average for the locality, and the practice achieved 100% of the available points within the 2014-15 Quality and Outcomes Framework.

Good health was promoted by the practice including self-management and a range of services including smoking cessation. Clinicians supported external events such as providing talks to groups to give information and advice, including topics such as stroke and chest conditions.

The practice had reviewed its skill mix following the retirement of a GP and introduced the role of the advanced nurse practitioner. The practice employed an information technology manager and had maximised the functionality of their computer system to make this work to benefit clinicians and make information more easily accessible. Regular engagement with the CCG pharmacist had facilitated a responsive system for medicines advice and audit.

Staff had received training appropriate to their roles and any further training needs had been identified and planned to meet these needs. Appraisals and personal development plans were in place for all staff. Staff communicated effectively with multidisciplinary teams, and engaged in regular meetings with them to benefit care and enhance outcomes for patients.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. For example, 91% of respondents said the last GP they spoke to was good at treating them with care and concern which was above the national average of 85%.Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. For example, 92% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 81%. Patients we spoke with on the day of the inspection, and responses we received on comment cards, reinforced the findings of the national survey.

The practice accommodated the individual needs of patients. For example, by implementing a communication needs alert on the patient records for those who were hard of hearing and may have problems talking on the telephone. We saw examples of how the reception team assisted patients attending for appointments.

The practice had implemented the gold standards framework for end of life care.

# Summary of findings

Information about services for patients and carers was available and easy to understand. We also observed that staff treated patients with kindness and respect and maintained confidentiality.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) and local GP practices to secure improvements to serviceswhere these were identified. For example, a local blood centrifuge service had been commissioned in response to a practice audit that highlighted delays in transportation of bloods which created false results indicating high levels of potassium results.

The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG), for example by updating the internal signage in the practice.

Feedback from some patients reported that access to a GP was not always available quickly, although urgent appointments were available on the same day. The practice were working to address the situation and were using triage to ensure patients could be given prompt advice and provided with an urgent appointment should this be required. However, the practice performed well with regards to some questions on access in the national GP survey. For example, 82% of respondents with a preferred GP usually get to see or speak to that GP compared with a CCG average of 60% and a national average of 60%.

The practice was sufficiently equipped to treat patients and meet their needs.

Information about how to complain was available although this was not prominently displayed. Learning from complaints was shared with staff, but was not generally discussed in collaboration with the full practice team to facilitate wider learning and identify any themes.

**Are services well-led?**

Good

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

It had a vision and strategy, and the partners and practice management team met on a weekly basis to focus upon key issues and business needs. Staff were clear about their own roles and responsibilities and how they contributed to the overall practice

# Summary of findings

objectives. There was a clear leadership structure and staff felt supported by management through regular and effective communications with colleagues at meetings. There was a high level of staff satisfaction and staff turnover was generally low.

The practice worked with other local practices and engaged effectively with their CCG.

The practice had a good range of policies and procedures to govern activity and held regular practice meetings.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and influenced developments in the practice. All staff had received inductions, regular performance reviews and attended staff meetings and CCG led learning events.

# 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 is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people such as rheumatoid arthritis, osteoporosis and coronary heart disease. The practice had achieved 100% of the available points in all of these areas which was above both the CCG and national averages.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had a designated telephone number that patients could ring to ensure a rapid response to meet their needs, as part of an enhanced service to avoid hospital admissions.

Regular meetings took place to review patients with unplanned hospital admissions and readmissions. Individual cases were discussed with the care co-ordinator, community matron and district nursing team, and where necessary with social services and the community mental health team. The practice had used care plans for their most vulnerable patients for a number of years.

GPs provided services to some older patients in local cottage hospital beds. Nurses supported health awareness events including a talk at the Stroke Society Rotary Club to raise the awareness of strokes.

### People with long term conditions

Good

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

Nursing staff had lead roles in chronic disease management, for example in asthma and coronary heart disease, and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. One appointment was offered to incorporate the needs of patients with two or more chronic diseases to review the patient holistically and to prevent them having to attend more frequently than necessary. Reviews encompassed the effect of the patient's condition's on work, relationships, housing, mobility, finance and impact on family or carers. This helped to signpost patients to other sources of support and outside agencies when necessary.

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All long-term condition patients had a structured annual review to check that their health and medication needs were being met, and individual care plans were developed as appropriate. For those people with the most complex needs, clinicians worked with relevant health and care professionals to deliver a multidisciplinary package of care. Joint appointments with the GP and nurse could be offered to patients with diabetes.

The practice promoted self-management plans. For example, the practice referred to self-help groups including 'Breathe Easy' for patients with chest conditions, and also provided input into this programme. The practice nurse supported health promotion events such as the Chronic Obstructive Airways Disease (COPD) world day in November 2015, and opportunistic spirometry sessions were held for patients who were thought to have risk factors.

There was good information on the practice website for patients with a long-term condition. One of the GPs had developed a pre-diabetes fact sheet in conjunction with the nursing team for patients at risk of developing type 2 diabetes. This provided basic advice on self-management and was part of a programme to monitor patients at risk of developing diabetes with support from the practice nurse.

**Families, children and young people**

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children who had a high number of A&E attendances. A monthly clinical team meeting which included the health visitor reviewed all children identified to be at risk and an alert system was in place on patient records to highlight those at risk.

Immunisation rates were relatively high for all standard childhood immunisations, for example five year old immunisation rates ranged from 96.1% to 100%. Appointments were available outside of school hours and the premises were suitable for children and babies. Combined postnatal and six week baby checks were offered to save patients time and increase efficiency within the practice.

The practice website had access to a good range of information on pregnancy and common conditions in young children, along with details of the child vaccination programme. The practice's triage system allowed for call backs to anxious parents, and offered urgent appointments when a child needed to be seen by a GP. Practice nurses undertook paediatric phlebotomy which would otherwise meant parents travelling to a hospital in Stockport.

# Summary of findings

The practice no longer provided family planning services on site, but patients still had access to this service locally.

A designated play area was available for children in the waiting area. Baby changing facilities were available and the practice welcomed patients to breast-feed on site.

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

Good

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

The practice was proactive in offering online appointment bookings, repeat prescriptions, and provided extended opening hours for GP and nurse appointments on a Friday morning from 7am. The practice had previously offered a Saturday morning appointment service but this had been withdrawn as it was not being utilised to good effect. This decision was supported by a comprehensive audit and patients also said they preferred to have access to earlier appointments on a week day.

Patients told us that it could be difficult to obtain an appointment, and this was reflected in some of the comments cards and within the national GP survey. For example, 81% patients said they were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and the national average of 85%. However, other comments received via the national GP survey indicated patients were positive about access, particularly to a named GP.

The practice supported a cohort of students based in Buxton. The practice sent representatives to attend the Derby University student fresher's week and promoted campaigns including sexual health and meningitis.

**People whose circumstances may make them vulnerable**

Good

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice cared for a homeless patient and worked with a local pharmacy to use their address as a communication channel. The practice worked with a local women's' home for those with problems including domestic violence and substance misuse. Following a recent significant event that occurred with one of the patients at this home, the practice had reviewed the circumstances that led to this event with staff from the home and the community

mental health team. Whilst this did not identify any specific learning for the practice, it demonstrated an effective methodology to review incidents of this type, and the practice received positive feedback regarding their input at the home.

The practice had carried out annual health checks for people with a learning disability and all patients on the practice's learning disability register had been invited to attend for this service. During 2014-15, 77% of these patients had attended and received an annual review. The practice offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people, and had signposted patients to various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children, and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

We observed some effective shared care plans that were in place for vulnerable patients at our inspection visit. One GP had a qualification in substance misuse and was experienced with this cohort of patients.

The practice held a monthly multi-disciplinary meeting to review the needs of end of life patients as part of the gold standards framework. This is a programme designed to provide excellent care for end of life patients working within recognised standards of care.

A list of older patients with memory difficulties was maintained to ensure they received any reviews required.

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

Good

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

QOF data reported an achievement of 100% for mental health related indicators which was 1.9% above the CCG average and 7.2% higher than the average for England. 77% of people on the practice mental health register had received an annual physical health check, and the practice encouraged carers to assist with the patient's attendance where this was appropriate. The practice used a computer search facility to follow up on patients with a diagnosis of depression who had not returned for their follow up appointments. The practice worked with multi-disciplinary teams in

the case management of people experiencing poor mental health, including those with dementia and carried out advance care planning for patients with dementia. 72% patients with dementia had received a face to face review in the preceding 12 months.

The practice had told patients experiencing poor mental health about how to access various types of support and we saw information about this available in the reception. Triage directed these patients for support quickly during periods of significant personal stress. There was a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Most staff had received training on how to care for people with mental health needs, including awareness of Alzheimer's Disease.

# Summary of findings

## What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing in line with local and national averages. There were 128 responses to the 301 surveys distributed which equated to a response rate of 43%.

The three results for this practice that were the highest compared to the local and national averages were:

- 82% of respondents with a preferred GP usually get to see or speak to that GP compared with a CCG average of 60% and a national average of 60%.
- 91% of respondents find it easy to get through to this surgery by phone compared with a CCG average of 76% and a national average of 73%.
- 83% of respondents describe their experience of making an appointment as good compared with a CCG average of 76% and a national average of 73%.

The area which were deemed as areas for improvement were:

- 60% of respondents usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 72% and a national average of 65%.
- 81% of respondents were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 87% and a national average of 85%.

We saw evidence that the practice had analysed the results of this survey and were reviewing how they could improve on the areas in which they received lower satisfaction scores. For example, they had reviewed the appointment system to accommodate the reduction in number of GPs to respond more effectively to both acute and chronic illnesses.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 31 comment cards of which 84% were very positive about the high standard of care received including being treated with kindness and respect. The negative responses related to the availability of appointments and there was one comment expressing dissatisfaction with the attitude of some reception staff.

# Buxton Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice manager specialist adviser 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 Buxton Medical Practice

Buxton Medical Centre is situated close to the centre of the town of Buxton in the Derbyshire High Peak. The practice is in a 1920s renovated and extended house which was purposely refurbished to provide general medical services and has housed the practice since 2000.

The practice is run by a partnership of four GPs (two male and two female). There is one part time nurse practitioner who is an independent prescriber, and there is also an existing part-time nurse practitioner vacancy. The practice has three part time practice nurses and a health care assistant. The clinical team is supported by a practice manager and assistant practice manager and a team of 12 administrative, secretarial and reception staff. As a training practice, GP registrars also work at the practice and at the time of our visit, two registrars were working at the practice. The practice also hosts the district nursing team employed by Derbyshire Community Health Services.

Patients reside in the town of Buxton and the surrounding rural areas. The registered practice population of 7,699 are predominantly of white British background, and are ranked in the fifth least deprived decile. The area is a mix of high affluence whilst also incorporating one of the most deprived neighbourhoods in Derbyshire. The practice age profile is broadly in line with national averages but has slightly higher percentages of patients over 65, and lower percentages of patients below the age of 18. The practice has a cohort of students registered with them due to the presence of a Derby University location in the town. This averages approximately 70 new patients per year, although there is a high turnover as other students finish their courses and re-locate to other areas. Buxton is a spa town and is a popular holiday destination attracting people visiting the Peak District area and the practice sees visitors on an urgent basis or for routine appointments as a temporary resident. GPs also cover some beds in the local cottage hospital.

The practice opens from 8am until 6.30pm Monday-Thursday, and from 7am-6.30pm on a Friday to accommodate people who cannot easily attend during standard opening times due to work commitments. GP morning appointments times are available from 8.10am-11.40am from Tuesday to Thursday, and from 7am on Friday. Monday surgeries are from 9.10am-12.30pm. Afternoon surgeries run from 2.30pm-5pm). The GP on call will continue to see any patients on an urgent basis up to 6.30pm. The practice closes once a month on a Wednesday afternoon for staff training and development. When the practice is closed patients are directed to Derbyshire Health United (DHU) via the 111 service. DHU provide an out of hours' service and see patients at the Buxton Cottage Hospital from 8am-12 noon at weekends and until midnight during weekdays. After 12pm at the weekend and between midnight and 8am Monday-Friday, patients can attend the out of hours' service based in Chesterfield or receive a visit if more urgent. Due to the location of the practice, patients may attend A & E services based in Chesterfield, Macclesfield or Stockport.

# Detailed findings

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 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 data, this relates to the most recent information available to the CQC at that time.

## How we carried out this inspection

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)

Before our inspection, we reviewed a range of information that we hold about the practice and asked other organisations including Healthwatch, NHS England and North Derbyshire CCG to share what they knew. We carried out an announced inspection on 27 October 2015. During our inspection we spoke with staff including GPs, practice nurses, the practice manager and a number of reception and administrative staff. In addition, we spoke with members of the district nursing team and the attached pharmacist regarding their experience of working with the practice team. We also spoke with patients who used the service, and representatives from the practice patient participation group. We observed how people were dealt with during their visit to the practice. Additionally, we reviewed 31 comment cards where patients and members of the public shared their views and experiences of the service.

Good

# Are services safe?

## Our findings

**Safe track record and learning**

Staff were encouraged to report any incidents including near misses, and a recording form was available on the practice's computer system. The practice ensured that any individual affected by a significant event received an apology and were told about actions taken to improve care. The practice reviewed the significant events at a weekly partners meeting.

We observed that recorded events were well documented with a full account of what had happened and the actions that had been taken in response to this. Twenty-five significant events had been recorded by the practice in the last two years, and this incorporated some patient complaints. Learning was cascaded to other members of the team where this was relevant to their role. There was not a specific meeting or annual review where all staff members were involved to review significant events which would have enabled greater analysis of trends and themes, and facilitated the wider sharing of learning.

We saw evidence that learning had been applied from significant events. This had arisen when a GP checked a patient's test results on the computer and noted that vital information did not appear on the screen unless the view was opened in full, as the system had truncated this. This information was immediately shared with the other doctors and then discussed at the next clinical meeting to ensure the whole medical team were aware of this important issue.

Safety alerts were cascaded to appropriate staff members. When a medication alert had been received, the CCG pharmacist attached to the practice or the Information Technology Manager would conduct a search of patients to determine if any follow up action was indicated. We saw evidence that this happened routinely, for example, an alert was received in October 2015 relating to mirabegron (used in the treatment of an overactive bladder) and the potential for increased blood pressure. A patient search was undertaken on the computer to see when the last blood pressure check had been undertaken for those who were prescribed this medication. The practice were in the process of considering if the patients needed to be recalled earlier for a review as a result of this alert.

**Overview of safety systems and processes**

The practice had defined and embedded systems, processes and practices in place to keep people safe, which included:

- Safeguarding arrangements were in place to protect children and adults from abuse that reflected relevant legislation and local requirements. We spoke to staff who demonstrated they understood their responsibilities for safeguarding and all had received training relevant to their role. There was a practice safeguarding policy in place which outlined how to report concerns if any staff member observed or became aware of a potential or actual safeguarding issue. For example, a doctor identified that a child with previous safeguarding concerns was in a situation where agencies such as school nursing and the health visitor were not involved for ongoing monitoring, and the partners subsequently escalated a referral through local safeguarding protocols to ensure the child's safety. There was a lead GP with responsibility for safeguarding, and monthly meetings took place to discuss and review safeguarding cases. The GPs attended externally held safeguarding meetings when possible, but would always provide reports if they could not attend. The GPs liaised regularly with the health visiting team regarding any safeguarding issues, and the health visitor attended the practice safeguarding meetings. There was an alert on the computer system to identify those deemed to be at risk.
- A notice was displayed in the waiting and consulting rooms advising patients that a chaperone was available if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We spoke with staff who acted as chaperones and they were able to give a clear account of their role.
- Safe systems were observed to review incoming correspondence from the out of hours' service and pathology laboratory results. These were reviewed daily by the GPs and any necessary actions were undertaken promptly and recorded.
- There were procedures in place for monitoring and managing risks to patient and staff

safety. There was a health and safety policy available and a Health and Safety Executive poster was displayed as a source of information for staff. Maintenance of the building was managed via a contract with an external provider. The practice had an up to date fire risk assessment and we saw that actions identified in the most recent fire risk assessment from December 2014 had been completed. Fire drills were carried out with the most recent trial evacuation having taken place in September 2015. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a good range of comprehensive risk assessments in place to monitor safety within the premises such as control of substances hazardous to health, lone working and legionella.

- We observed the premises to be tidy and kept to a good standard of maintenance. However, we found standards of cleanliness would benefit from being reviewed. For example, many areas accessed by patients such as the entrance foyer and the baby changing facility were not part of the cleaning schedule. We did not see any evidence to support the cleaning of medical equipment within the practice in line with the practice policy. Most consulting rooms were carpeted and had been deep cleaned in October 2014. A practice nurse was the infection control clinical lead, and there was an infection control protocol in place. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. All staff had received up to date training in infection control and prevention.
- Regular medication audits were carried out with the support of the locally based CCG pharmacist to ensure that the practice was prescribing in line with best practice guidelines for safe prescribing. Systems were in place to follow up patients who did not collect their prescriptions after three months, although the practice were aware that they needed to review this to a shorter timescale for patients including those with mental health difficulties. There was a large stock of unused prescription pads and systems in place to store and monitor their use was not in accordance with the practice's own prescription security protocol. However, the practice provided assurance that they would review this situation.
- Vaccines were in date and kept in refrigerators which were monitored for temperature control, although action was recommended to make sure there was a record of these temperatures every day as we noted three gaps in a two month period.
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- All members of the practice team had received appropriate clearance from the DBS. The practice had group indemnity cover for all the GPs and nursing staff.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty
- The practice ensured the Care Quality Commission were informed via the statutory notification process for any relevant untoward event

**Arrangements to deal with emergencies and major incidents**

There was a system to notify the rest of the team if a medical emergency occurred. A message appeared on all open computer screens advising which room required assistance, and there was access to an internal panic alarm. All staff had received annual basic life support training and there were emergency medicines available in an accessible location. All the medicines we checked were in date and fit for use. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible and all staff knew of their location.

The practice had a comprehensive business continuity plan in place for major incidents such as loss of services including electricity or building damage. This plan had been updated in October 2015 and included emergency contact details for staff. Copies of the plan were kept off site for reference in the event of an emergency which prevented access to the building.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice routinely used National Institute for Health and Care Excellence (NICE) best practice guidance and other national and locally agreed guidelines and protocols as part of their consultations with patients. The practice had systems in place to ensure all clinical staff were kept up to date. The practice were in the process of implementing the 'Map of Medicine' to further enhance access to clinical information and guidance. The Map of Medicine is an electronic resource designed to give clinicians instant access to locally customised pathways, standardised referral forms and clinical information to assist with consultations.

The practice employed an IT Manager who had worked to maximise the functionality of the practice's computer system. This made the practice more efficient in terms of using standardised templates, undertaking clinical searches, operating patient recall systems, and providing performance data. The practice had acquired new software to increase efficiency including voice recognition software, and an integrated spirometry machine (spirometry is a test to diagnosis and monitor people with lung disease) to input data directly into the patient record.

**Management, monitoring and improving outcomes for people**

The practice participated in the Quality and Outcomes Framework (QOF), a system intended to improve the quality of general practice and reward good practice. The latest published results for 2014-15 were 100% of the total number of points available, with 10% exception reporting (compared to a CCG figure of 11%). The exception reporting figure is the number of patients excluded from the overall calculation due to factors such as non-engagement when recalled by the practice for reviews. A lower figure demonstrates a proactive approach by the practice to engage their patients with regular monitoring to manage their conditions. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-15 showed;

- Performance for diabetes related indicators at 100% was better compared to the CCG average of 96.7% and the national average of 89.2%
- The percentage of patients with mental health related indicators was 100% compared against a CCG average of 98.1% and a national average of 92.8%
- Peripheral arterial disease indicators had an achievement figure of 100% which was 1.4% higher than the CCG average and 3.3% higher than the England average

Clinical audits were undertaken by the GPs to demonstrate quality improvement and improve care, treatment and outcomes for patients. There had been 20 clinical audits completed in the last two years, five of these were completed audits where the improvements made were implemented and monitored. For example;

- The practice had undertaken an audit on hyperkalaemia (an elevated level of potassium in the blood). Some patients had false positive readings of abnormal high blood potassium levels which led to repeated blood tests or hospital admission. It was determined that this had been created by delays in transporting samples to the laboratory, and also seasonal variation. The findings were shared with other local practices and the CCG. This resulted in the CCG investing in a local facility using savings from the avoidance of unnecessary hospital admissions.
- The practice worked closely with the CCG pharmacist who attended the practice on a daily basis. CCG prescribing audits had been undertaken at the practice. For example, in response to an audit highlighting the practice as a high prescriber of therapies for lung disease, such as inhalers, it was determined that this had led to a reduction in hospital admissions and was consequently deemed to be a cost effective approach. We saw evidence of good engagement with the wider CCG medicines optimisation team and the practice looked likely to underspend on the current annual prescribing budget.

**Effective staffing**

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had re-designed their skill mix arrangements in response to the current national GP recruitment difficulties. Two Advanced Nurse Practitioner (ANP) roles had been introduced earlier in 2015, although one post had recently become vacant. The role of the ANP was still in development at the time

Good

# Are services effective?

## (for example, treatment is effective)

of our inspection but was already having an impact in terms of alleviating pressures on GPs for home visits, as suitable visits were allocated to the ANP. The practice had two independent nurse prescribers that were able to deal with a number of patients who would otherwise have had to see a GP.

- There was an active appraisal system in operation at the practice, and all staff had received their appraisal in the preceding 12 months. Staff were supported to undertake training to meet personal learning needs to develop their roles and enhance the scope of their work. For example, the ANP informed us that the practice was very keen to support the forthcoming revalidation programme for nurses in terms of training and preparation.
- The practice had an induction programme for newly appointed members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. We saw examples of completed induction documentation.
- Staff training records evidenced training that included safeguarding, fire procedures and basic life support. Staff had access to and made use of e-learning training modules and in-house training. We saw that training records were updated on the practice intranet system.

**Coordinating patient care and information sharing**

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care plans, medical records and test results. Care plans were observed for patients with a long term condition, learning disability, mental health and carers. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. 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 identified via safeguarding. These meetings included community health services representatives including care a co-ordinator, district nurse and health visitor and where necessary with social services and the community mental health team. Care plans were routinely reviewed and updated.

**Consent to care and treatment**

Clinical staff demonstrated a thorough understanding of 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, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. We saw an example of an instance in which a GP had reviewed a care home patient who wished to return to her own home. The doctor assessed the patient had the capacity to make this decision and subsequently involved adult safeguarding and the independent mental capacity advocate (IMCA) service to ensure the patient's wishes were acted upon.

Written consent was observed in 100% patients receiving minor surgical procedures.

**Health promotion and prevention**

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet or smoking. Patients were then signposted to the relevant service, such as the exercise by prescription scheme or the smoking cessation service. There had been 76 patients who had stopped smoking during the previous 12 months achieved through attending the in-house and Derbyshire Community Health Services smoking cessation services.

The practice referred to self-help groups including 'Breathe Easy' for patients with chest conditions, and supported health promotion events such as the Chronic Obstructive Airways Disease (COPD) world day at which the practice nurse ran opportunistic spirometry sessions.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme

Good

# Are services effective?

## (for example, treatment is effective)

was 82.28%, which was comparable to the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

Childhood immunisation rates for the vaccinations given were comparable to the CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93.8% to 100% and five year olds from 96.1% to 100%. Flu vaccination rates for the over 65s were 70.91%, and at risk groups 50.37%. These were slightly below the CCG averages of 73.24% and 52.29% respectively.

Patients had access to appropriate health assessments and checks, including health checks for new patients and NHS health checks for people aged 40–74. The practice had achieved 84% of its annual target for completed health checks in the first 11 months of 2014-15. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The PPG produced a quarterly patient newsletter called 'Patient Matters' to help inform patients about new developments in the practice, and this newsletter also provided advice and health promotion. 400 copies were produced for distribution within the practice. The next newsletter is intended to provide information on diabetes.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

Throughout the inspection, we found that patient care and a genuine desire to do the best for patients was the primary focus of the practice team at all levels. This was integral to the practice team's everyday work.

We saw that members of staff were polite and helpful to patients both attending at the reception desk and on the telephone and people were treated with dignity and respect. During our inspection we observed several examples where reception staff came to assist patients including offering a wheelchair, providing water, and assisting a patient to get through a door. Reception staff told us that they tried to help frail patients, for example by contacting the pharmacy to check prescriptions were ready for collection before the patient attended. If the reception team noticed patients were struggling with basic tasks, they ensured that clinicians were made aware so that individuals were appropriately assessed. Staff were able to move patients who wanted to talk about sensitive matters, or if they appeared distressed, into an area which had been created next to the reception desk to maintain their confidentially.

The majority of the 31 patient CQC comment cards we received were positive about the service experienced. There was only one negative response regarding the attitude of staff. Patients said they felt the practice offered an excellent service and that staff were helpful, compassionate and treated them in a dignified and respectful manner. We spoke with two members of the patient participation group (PPG) on the day of our inspection. The PPG members told us they were extremely satisfied with the care provided by the practice and said their views were listened and responded to. For example, signage had been improved within the practice further to comments made by the PPG.

Results from the national GP patient survey showed the practice was generally in line with CCG averages and above the national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 93% of respondents said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 90% of respondents said the GP gave them enough time compared to the CCG average of 91% and national average of 87%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%
- 91% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.
- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.
- 94% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

**Care planning and involvement in decisions about care and treatment**

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told they usually had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 92% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 81%
- 90% of patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 86%.

Staff told us that translation services were available for patients who did not have English as a first language, although we did not see any notices in the reception areas informing patients that this service was available.

**Patient and carer support to cope emotionally with care and treatment**

Good

# Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and 2% of the practice list had been identified as carers and were being supported, for example, by offering health checks, flu vaccinations and referral for social services support. Information including a poster about the Derbyshire Carers Association, and details of a course for carers were on display to ensure carers knew how to access different support options available to them.

The practice worked within the gold standards framework for their end of life patients. Staff told us that if families had suffered bereavement, their usual GP either visited or contacted them. Follow up support might be offered if required, or the family could be signposted to appropriate support agencies.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice offered early appointments from 7am for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with more complex needs such as some older people or those with a learning disability.
- Home visits were undertaken by either the ANP or the on-call doctor. The surgery used i-pads for the visits to enable access to the patient's history and to record notes contemporaneously. This also allowed for further visits to be added whilst the GP was out in the community to save time and resources.
- Due to its location in the High Peak, the practice was able to manage adverse weather including snow, by implementing increased availability of telephone consultations. The practice also worked with colleagues in the other local practices to address difficulties faced during the winter months.
- GPs provided primary medical services to some patients in the local cottage hospital
- Urgent access appointments were available for children and those with serious medical conditions.
- The practice utilised an alert on the computer system to highlight specific communication needs. For example, an alert for a deaf patient stated to always contact via text message and not to use the telephone. The practice had disabled facilities, although we observed that access via the inner main doors could be problematic to wheelchair users and mothers with prams. The entrance to the disabled toilet was also noted to be difficult to access for patients in a wheelchair. A hearing loop was available on site and patients had access to translation services.
- The practice hosted the Citizens Advice Bureau once a week, and a counsellor attended the practice for two sessions each week.
- The practice used audit as a means of reviewing patients to ensure they were receiving treatment in line with recognised guidance. For example, further to an article in the British Medical Journal highlighting benefits from the prescribing of beta-blocker medication (drugs used in the treatment of irregular heart rates) for patients with lung and cardiac disease, an audit was used to identify this cohort of patients. Whilst this did not result in any changes to prescribing in these patients, it demonstrated the practice was proactive in reviewing patients in response to new or revised guidance.

**Access to the service**

The practice was open between 8am and 6.30pm Monday to Thursday, and extended hours were offered from 7am to 6.30pm on Friday. The practice closed at 1pm one Wednesday each month for staff training and development. GP morning appointments times were available from 8.10am-11.40am from Tuesday to Thursday, and from 7am on Friday. Monday surgeries were from 9.10am-12.30pm. Afternoon surgeries ran from 2.30pm-5pm) and the GP on call continued to see patients on an urgent basis up to 6.30pm. Pre-bookable appointments could be booked up six to eight weeks in advance. On the day of our inspection, we saw that the next advanced booking varied from one week for one doctor, to up to three weeks for other GPs.

The practice had previously opened on a Saturday morning. However, the practice found that uptake by patients was limited and so following feedback from patients and the results of a comprehensive audit, it was decided that this should be ceased, and the early morning Friday appointments were then introduced.

The practice operated a nurse-led triage system between 8-9.30am and from 1.30-2.30pm. This allowed urgent appointments to be allocated to those with acute needs, and were unable to await the first available routine appointment. Urgent cases were seen on the day.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mixed. This was supported by some of the people we spoke to on the day, and from comments received on the cards, which indicated that patients had difficulty in obtaining an appointment when they needed them. For example, the national survey indicated:

- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 75%.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- 91% patients said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.
- 83% patients described their experience of making an appointment as good compared to the CCG average of 76% and national average of 73%.

However,

- 81% patients said they were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and the national average of 85%
- 57% patients said they feel that they do not normally have to wait too long to be seen compared to a CCG average of 63% and a national average of 58%
- 60% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%.

The practice were aware of this issue which had arisen due to the recent retirement of one of the GP partners and the difficulties associated with recruiting new GPs. We saw that the practice had analysed the patient survey results and had devised an action plan to improve access to appointments. This included actions to re-organise the appointment system and to utilise the ANP role as part of the triage process. Locum GPs were also being used to increase the availability of GP consultation time.

Patients told us that they were kept informed when appointments ran late and information was also displayed about this on the electronic display system in the waiting area.

The health care assistant worked on one morning each week to undertake NHS Health checks and blood pressure readings. The practice had commissioned phlebotomy services from another provider and only undertook emergency or paediatric phlebotomy within the practice. Patients attended one of three locations in the town to access the routine phlebotomy service, and patients we spoke to did not indicate that this caused them any inconvenience. However, bookings for this service had to be made via the practice's reception which had an impact for reception staff, although patients reported that they could get through to the practice easily by telephone.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures including the patients' complaint leaflet required some minor updates in line with recognised guidance. There was a designated responsible person who handled the complaints in the practice.

Information to help patients understand the complaints system was displayed at the side of the reception desk, although this was not easily viewed. Patients we spoke with were generally unaware of the process to follow if they wished to make a complaint, although they told us that they would feel confident to report any concerns should this arise.

The practice had received 14 written complaints and nine verbal complaints in the previous 12 months. We looked at a selection of the written complaints received in the year and found that these had been fully investigated and responded to within an appropriate timescale. Apologies were provided to patients although some responses were occasionally defensive, rather than remaining factual.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, following a delayed diagnosis in a patient presenting with symptoms of diabetes, arrangements were reviewed and a system for requesting urgent blood tests via the practice computer system was highlighted to the GP involved, and to the wider clinical team.

# 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 clear vision to deliver high quality care and promote good outcomes for patients. The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

**Governance arrangements**

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff via the intranet
- A comprehensive understanding of the performance of the practice was ensured by engaging in local and wider CCG meetings. Data was shared to highlight how the practice performed in comparison to other practices in the CCG. This enabled the sharing of good practice and to highlight key areas for the practice to focus upon, including improvements to access.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

**Leadership, openness and transparency**

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. Partners held a weekly meeting focussed upon business needs, and also to review significant events and complaints. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff.

The partners worked with their CCG and proactively reviewed areas such as referral management and prescribing. They attended CCG meetings and one GP sat on the CCG's Clinical Reference Group.

Staff told us that monthly team meetings were held, and that there was an open culture within the practice. They had the opportunity to raise any issues at team meetings and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys, complaints received, and via a suggestions box. There was an active PPG which met on a regular basis and submitted proposals for improvements to the practice management team. For example, members of the PPG told us that improvements had been made regarding disabled access at the practice. The PPG highlighted this need and wrote a support letter for a grant application to install electronic access doors, which was successful.

Staff told us they felt empowered to give feedback or provide suggestions on how things could be improved with colleagues and management. Good work was acknowledged by the practice management and two members of the practice team had been nominated for award programmes being run by the CCG. GP registrars told us they were supported by the partners in consultations and home visits, and had a very positive experience whilst working at the practice. They were involved in practice meetings and were given protected time to ensure their learning needs were met. Employees spoke positively about their experience of working for the partners and there was a low turnover of staff. The management team aimed to support the staff in a number of ways, for example, alerts were added to electronic staff files to inform managers when eye tests were due for habitual computer users.

**Innovation**

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes

# Are services well-led?

Good

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

to improve outcomes for patients in the area. For example, the development of a local centrifuge service had been funded further to the audit on abnormally high readings of blood potassium which had been linked to the delays in transporting bloods to pathology.

The practice worked with other local practices and with their CCG and were involved in the 21st century work across North Derbyshire to deliver a more joined up approach to future service delivery.