Lime Grove Medical Centre

Quality Report

Lime Grove Medical Centre
Lime Grove Walk
Matlock
Derbyshire DE4 3FD
Tel : 01629 581586
Fax: 01629 57006
Website: www.limegrovemedicalcentre.co.uk

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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 inspected Lime Grove Medical Centre on 23 October 2014. We inspected this service as part of our new comprehensive inspection programme.

Overall, we rated the practice as good, although there was one area where the practice should make improvements. Our key findings were as follows:

- Patients reported good access to the practice and continuity of care, with urgent appointments available the same day.
- Patients said, and our observations confirmed, they were treated with kindness and respect.
- Patient outcomes were at or above average for the locality and good practice guidance was referenced and used routinely.
- The practice was visibly clean and tidy.
- The practice learned from incidents and took action to prevent a recurrence.

We saw an area of outstanding practice including:

The practice had developed a tool for care coordination and case management called HAVOC (Hospital admissions, A&E attendances, Visits, Out of Hours for Case management).

However, there were areas of practice where the provider needs to make improvements.

The provider should :

Check emergency medicines and have systems in place to ensure all medicines within the practice are in date.

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 and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. However the practice should check emergency drugs to ensure all items are in date.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE (National Institute for Health and Care Excellence) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams. We saw that the practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients diagnosed with dementia had their care plans reviewed in the previous 6 months. This was significantly higher than the national average of 83.2%.

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. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The GP national survey from July 2014 showed 92% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

The practice had developed a tool for care coordination and case management called HAVOC (Hospital admissions, A&E attendances, Visits, Out of Hours for Case management).

Summary of findings

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 NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make non urgent advance appointments with a named GP and that there was continuity of care. Patients did however comment that when phoning to book a same day appointment they were sometimes unable to get through.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and 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 the practice had good outcomes for conditions commonly found amongst older people. Screening was carried out for those patients with signs of dementia. The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The medical, social and general support needs were reviewed regularly by a GP, community matron, designated practice nurse, or the district nursing service. The practice had developed a tool for care coordination and case management called HAVOC (Hospital admissions, A&E attendances, Visits, Out of Hours for Case management). This tool allowed up to date monitoring of patients.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients had reviews to check their health and medication needs were being met. The practice maintained a list of those patients who needed home visits. Routine aspects of care were undertaken by community staff and then discussed with allocated GP. For those people with the most complex needs the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, the practice had processes in place to identify and support vulnerable local families in these circumstances through ongoing contact or correspondence. Patients told us that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with examples of joint working with midwives and health visitors.

Summary of findings

The lead children's safeguarding GP was aware of vulnerable children within the practice and records demonstrated good liaison with partner agencies such as the police and social services. The practice held regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The practice was open from 7am – 6.30pm on Monday, Tuesday, Thursday and Friday and from 7.30am - 6:30pm on Wednesday. This meant the practice was open before and after normal working hours for patients who required appointments.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice was signed up to the learning disabilities local enhanced service and as part of their contract they provided an annual health check to patients on their learning disability register. The practice offered longer appointments for patients, if required. The practice offered interpreter services if required.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations including the Citizens Advice Bureau who held a weekly session at the practice. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health had received an annual

physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice website signposted patients to a range of services available to all those experiencing poor mental health. It had 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. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey undertaken in July 2014. A survey of 140 patients was undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires were sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey from July 2014 showed the practice was rated 'among the best' for patients who rated the practice as good or very good with 95% of patients confirming this view. The practice was rated highly in respect of its satisfaction scores on consultations with doctors and nurses. 96% of practice respondents indicated the GP was good at listening to them and 98% of respondents had confidence and trust in the last GP they saw or spokewith.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 6 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One of the comments indicated that the service the patient had received from the practice was excellent. Another praised the reception staff on how they had been under pressure at times but worked well and that the practice nursing staff had been extremely helpful and polite.

We spoke with 6 patients in the reception and waiting areas of the surgery. All of the people we spoke with were very happy with the service they received. All of the people we spoke with told us that the GPs and the nurses were caring, patient, kind and treated them with respect. Some patients however were unhappy with the long waiting time for the telephone to be answered when trying to book appointments.

Areas for improvement

Action the service SHOULD take to improve

Check emergency medicines and have systems in place to ensure all medicines within the practice are in date

Outstanding practice

The practice had developed a tool for care coordination and case management called HAVOC (Hospital admissions, A&E attendances, Visits, Out of Hours for Case management).

HAVOC was a tool developed by the practice for the monitoring which patients had been to Hospital, A&E, had been visited at home, had received an Out of Hours visit, were under the Care of the Community Matron and had a Care plan using data readily available at practice level.

Lime Grove Medical Centre

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 a Practice Manager

Background to Lime Grove Medical Centre

Lime Grove Medical Centre delivers primary medical services under a personal medical services (PMS) contract between themselves and NHS England. The practice serves a patient population of 8089. There are roughly equal numbers of patients aged over 65, under 18 and of working age.

There are three male partner GPs and three female salaried GPs, who provide 76 sessions a week between Monday and Friday. The practice is open from 7am – 6.30pm on Monday, Tuesday, Thursday and Friday and from 7.30am - 6:30pm on Wednesday. The clinical sessions of individual doctors and nurses vary within these hours.

The practice closes once a month at 1pm for staff training purposes. The GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service when the surgery is closed at the weekends. This service is provided by Derbyshire Health United.

The doctors are registered to carry out minor surgical procedures. There is an all female nursing team consisting of a nurse practitioner, a nurse specialist, a practice nurse, and three health care assistants.

The practice provides a number of clinics providing family planning services, cervical smears, antenatal and postnatal care, children's immunisations, child health surveillance, travel and yellow fever vaccinations, well person checks, over 75's health checks, flu and pneumococcal vaccinations, blood pressure, hypertension, asthma and more complex chronic disease management.

Lime Grove Medical Centre was opened in 1993 as a modern, purpose built, health centre. The surgery facilities are all provided on the ground floor level which can easily be accessed by people who use wheelchairs. An accessible toilet is provided adjacent to the waiting room area. The lower ground floor is operated by the Derbyshire Community Health Services and provides facilities like chiropody and speech therapy.

An administration team comprising a full time practice manager and deputy manager, six administration staff, eight reception staff, an office assistant and two cleaners are employed to support the day to day running of the practice. This team were highly praised by all the patients we spoke with.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act 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, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

Detailed findings

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, we always ask the following five questions of every service and provider:

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection we reviewed a range of information we held about the practice and asked other organisations including Healthwatch, the CCG and the Area Team to share what they knew. We reviewed some policies and procedures and other information received from the practice prior to the inspection.

We carried out an announced inspection on 23 October 2014. During our inspection we spoke with all the staff available on the day. This included two of the GP partners, two nurses, the practice manager, four administration staff and two members of reception. We also spoke with six patients who used the service and one member of the patient participation group. We received 34 CQC comments cards which had been completed. We observed interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated Quality Education and Study Time (QUEST) meeting was held monthly to review actions from significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager via e-mail or completed these manually and placed them in a sealed envelope. The practice manager showed us the system she used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training in safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans

There was a chaperone policy, which was visible on the waiting room noticeboard, consulting rooms and minor surgery room. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone the reception staff had also received chaperone training having been previously DBS checked. In the event of the requirement for a male chaperone a male GP would be available.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead children's safeguarding GP and the lead vulnerable adults safeguarding GP were both aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Prescribing was carried out by appropriately qualified clinical staff; these being the GPs and two members of the nursing staff who were qualified as nurse prescribers who received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). These were stored in a safe and locked with a key and the storage was suitable and fixed. Only authorised staff members could access the controlled drugs. All controlled drugs we saw were in date and tallied with the records held and used at the practice.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer to make sure the readings were correct.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Good

Are services safe?

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an access audit when it was identified that the accessible toilet required that a pull cord and new seat be fitted. These were fitted within days of the audit being carried out.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

The notes of the practice's significant event meetings showed that staff had discussed a number of medical matters concerning patients and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated.) and hypoglycaemia (a medical emergency that involves an abnormally diminished content of glucose in the blood). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. Most of the medicines we checked were in date and fit for use except for the case of an injectable drug kept for use in an emergency such as a cardiac arrest which was two months out of date. We immediately pointed this out and as a result of this the drug was removed and replaced with an in date item. We told the practice that they should check emergency medicines and have systems in place to ensure all medicines within the practice are in date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, in the case of damage to the building that resulted in the practice having to move elsewhere there was an agreement in place to use rooms' in a community building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease, palliative care, chronic obstructive pulmonary disease (COPD) and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

We saw data from the local Clinical Commissioning Group (CCG). This demonstrated the number of patients diagnosed with dementia whose care had been reviewed in the previous 15 months was better than similar practices within the CCG and nationally. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers who were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

The practice offered personalised care to meet the needs of the older people in its population. Screening was carried to identify whether patients had a diagnosis of dementia. The practice had written to patients over the age of 75 years to inform them who their named GP was.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

The practice showed us seven clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit

For example, we saw a clinical audit on the self-management of COPD (Chronic Obstructive Pulmonary Disease – a respiratory disease) looking at whether the provision of self-management plans and anticipatory medicines resulted in a decrease in unplanned admissions. This was a completed cycle carried out over a period of two years between June 2012 and June 2014. The initial audit identified 75% of patients were on a self-management plan and 78% were in receipt of anticipatory medicines. These figures had increased to 92% and 95% respectively on reaudit and the findings demonstrated that the number of unplanned admissions had reduced from seven to five through improved self-management.

GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients diagnosed with dementia had their care plans reviewed in the previous 6 months. This was significantly higher than the national average of 83.2%. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had made improvements in end of life care. This was by the way of audits carried out within the practice which had led to changes including the renaming of the 'palliative care' register to 'supportive care register' to embrace the wider concept of offering regular support to patients, rather than focus on patients at the end of their life, this included a specific question regarding consent for all patients placed on the register.

The practice held regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. All patient deaths were discussed at the multidisciplinary meeting. Persons who experienced bereavement were given support and were signposted to local services.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example in children and vulnerable adult safeguarding. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles such as those seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading

Good

Are services effective?

(for example, treatment is effective)

and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings every week to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice signposted patients experiencing poor mental health to various support groups and voluntary organisations. It had a system in place to follow up on patients who attended accident and emergency (A&E) where they may have been experiencing poor mental health.

The practice used a 'buddy' system whereby GPs were paired up to ensure all clinical letters/results were medically screened and actioned in the event of them being absent.

The practice shared premises with the lower ground floor being operated by Derbyshire Community Health Services providing services like chiropody and speech therapy. The staff at the practice were able to refer patients to the services directly.

The practice also hosted advice sessions for Lime Grove patients on Thursday afternoons through Derbyshire Districts Citizens Advice Bureau.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 3807 referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

All results from blood tests results were provided electronically. The GP who ordered the test received the results and these were checked on day they arrived. The practice had a nominated deputy to assess test results if the GP who requested this was absent from the practice and all emergency test results went to the duty GP.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use.

Consent to care and treatment

We found that staff were aware of the legislation regarding the consent to care and treatment and were able to describe how they implemented it in their practice. All GPs and nurses had received Mental Capacity Act training (MCA). All other practice staff had received in house training in respect of the MCA.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

Good

Are services effective?

(for example, treatment is effective)

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice also offered NHS Health Checks to all its patients aged 40-75.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability; this numbered 51 in total. Practice records showed these had all received a health check up in the last 12 months. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 79.3%, which was equivalent to the CCG average and over 5% higher than the average for England. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from July 2014, a survey of 140 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. 95% of respondents confirmed this was their view. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 96% of practice respondents saying the GP was good at listening to them and 98% saying had confidence and trust in the last GP they saw or spoke to.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 6 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One of the comments indicated that the service the patient had received from the practice was excellent. Another praised the reception staff on how they had been under pressure at times but worked well and that the practice nursing staff had been extremely helpful and polite.

We spoke with 6 patients in the reception and waiting areas of the surgery. All of the people we spoke with were very happy with the service they received. All of the people we spoke with told us that the GPs and the nurses were caring, patient, kind and treated them with respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk in a separate office and therefore keeping patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

The practice liaised with other appropriate agencies and also signposted patients via the website, leaflets or advertisements on the screens in the waiting room.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey in July 2014 showed 92% of practice respondents said the GP involved them in care decisions and 95% felt the GP was good at explaining treatment and results.

Patients we spoke with on the day of our inspection 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 us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and patient website also told people how to access a number of support groups

and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The medical, social and general support needs of older people were reviewed regularly by a GP, community matron, designated practice nurse, or the district nursing service. The practice had developed a tool for care coordination and case management called HAVOC (Hospital admissions, A&E attendances, Visits, Out of Hours for Case management).

HAVOC was a tool developed by the practice for the monitoring which patients had been to Hospital, A&E, had been visited at home, had received an Out of Hours visit, were under the Care of the Community Matron and had a Care plan using data readily available at practice level. This arose out of the difficulty that the Secondary Uses Service (SUS) data was not up to date. SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Last year the practice total admission rate had gone from being above to below the CCG average, and medical admissions rate had reduced from 60 to 53 /1000.

A computer company has developed HAVOC further, so that it can be used in case management, and across SYSTMONE & EMIS practices. (These are centrally hosted clinical computer systems available to GPs). HAVOC displayed the near real-time activity of patients, can be used to monitor care processes across the practice in a bespoke way, and has created multiple reports with just one computer search.

HAVOC has been shared at CCG level. One practice has been trialling it and another is looking at trialling it at present.

The reports have been used weekly at the MDT meeting, and monthly for the Admissions Avoidance directed enhanced services (DES) review.

In addition, HAVOC had been used to monitor the process of the Care Home Local Enhanced Service (LES) and palliative care.

Reports can be created in a bespoke manner, the practice was therefore prepared to monitor the processes of any forthcoming service requirements, for example the diabetes service reconfiguration locally and the delivery of care to patients with dementia and their carers.

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

Bereaved patients were discussed at the weekly Multi-disciplinary Team (MDT) meeting and a decision made as to the best way to support the carers at that time.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The GPs attended meetings of the patient participation group (PPG) and as a result had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from them. These were to update leaflets/patient brochures, update the PPG website and update the practice website.

Emergency processes were in place and referrals made for patients with long term conditions that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients had reviews to check their health and medication needs were being met.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. This included services for patients who were housebound and considered to be vulnerable, those with a learning disability, patients with mental health issues and also provided links to the Derbyshire Carers Association for carers of vulnerable patients.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice was situated on the ground and first floors of the building with services for patients on the ground floor. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The majority of patients within practice were English speaking though it could cater for other different languages through translation services.

Access to the service

Appointments were available from 7am to 6.30pm on Mondays, Tuesday, and Thursday, Friday and from 7.30am to 6:30pm on Wednesday. The clinical sessions of individual doctors and nurses varied within these hours. The surgery also offered additional pre-bookable appointments Monday Tuesday, Thursday and Friday from 7am to 8am and on Wednesday only from 7:30am to 8am.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system with posters displayed in the reception and waiting areas. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at eight complaints received in the last 12 months and found that all of those had been satisfactorily handled, dealt with in a timely way with openness and transparency when dealing with the complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and it showed that the appointment system had caused most concern. The practice had looked at various ways of improving access to patients.

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. We found leaders had a shared purpose and strived to deliver and motivate staff to succeed. It was evident in discussions we had with staff throughout the day that this was a shared vision and was fully embedded.

The practice displayed that as a service it was patient focused, aimed at attaining the highest standards of care and one that was accessible. They have stated aims for the future to maintain and improve services, for example for patients with a learning disability. The practice was aiming to become a GP training practice and offered four week placements to final year medical students.

The practice had links with local schools and had provided several presentations to pupils about health issues. Pupils from a local school made paintings promoting healthy living and these were displayed throughout the waiting and reception area.

Governance arrangements

The practice had in place leads for key areas such as clinical governance, information governance, infection prevention and control (IPC), medicines management, care homes and safeguarding. Staff were able to tell us who the relevant leads were. From our discussions with staff we found that they looked to continuously improve the service being offered. We saw evidence that they used data from various sources, incidents, complaints and audit to identify areas where improvements could be made.

The practice adopted a culture of transparency and openness and all staff were clear about roles and responsibilities. All staff spoken with said the management team supported and valued them and that they were encouraged to feedback any concerns that they might have.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at five of these policies and procedures and staff had completed a cover sheet to confirm that they had read the policy and when. All five policies and procedures we looked at had been reviewed annually and were up to date.

The practice held regular governance meetings where matters such as performance, quality and risks were

discussed. For example, the practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed it was performing above the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw that QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as an assessment of legionellosis risk at the practice. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, disciplinary procedures, induction policy, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and patients agreed telephone consultations would be useful.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG) which has steadily increased in size. The group had identified that it was not representative of patient population in general with 90% of the members aged over 55 and 100% of members being white British, the practice had made efforts to try and encourage participation from other groups of patients by notices in the waiting room and on the website. PPG members had been active in encouraging other patients to join. The PPG had however recruited two members of the local sixth form to the group.

The PPG had carried out quarterly surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the PPG website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around chaperoning at the staff away day and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Performance data was regularly reviewed, reported, disseminated and used as a basis to change or develop services. For example housebound patients were now visited and monitored for long term conditions by practice nurses and/or GPs.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was aiming to become a GP training practice and offered four week placements to final year medical students. Patients were always asked if they were happy for a student to be present during a consultation before it began. It was always possible to make alternative arrangements to comply with patient preferences.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.

The practice had developed an in-house tool for care coordination and case management called HAVOC (Hospital admissions, A&E attendances, Visits, Out of Hours for Case management). This tool allowed as close to “Real Time” monitoring of patients as was possible.