Kelvingrove Medical Centre

Quality Report

Kelvingrove Medical Centre
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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 Kelvingrove Medical Centre 14 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, and responsive and well led services. It was also good for providing services for all population groups.

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 and near misses.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients told us they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

- Ensure records of significant event investigations contain all relevant information, including follow up, learning and further investigation.

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.

Robust systems to safeguard vulnerable patients were in place and staff were aware of their responsibilities with these. Staff were aware of how to raise concerns, and to report incidents and near misses. Incidents were regularly reviewed and lessons learned were communicated to all staff to support improvement. The majority of information about safety was recorded, monitored, appropriately reviewed and addressed. However the quality of incidents records and investigations was not consistent. Risks to patients were assessed and well managed. There were usually enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes had been consistently at or above local and national averages for the last three years, with the practice achieving 100% of the available points in relation to the vast majority of indicators. Where they did not achieve 100% their performance was still above the average for the CCG and England. Guidance from the National Institute for Health and Care Excellence was communicated to all staff and used to assess patients' needs and ensure care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

The quality and effectiveness of care was regularly reviewed and benchmarked against local and national standards. Where improvements were identified, robust action plans were implemented.

Staff had received training appropriate to their roles and any further training to improve staff skills and improve patient outcomes was provided for example management of diabetes and asthma. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services.

National patient survey data showed that patients rated the practice higher than others for several aspects of care, including attitude of staff and involvement in decisions about care and treatment. This

Summary of findings

was confirmed by patients we spoke with on the day. Patients told us they were treated with dignity and respect. They were able to make informed decisions about their care and treatment and that they valued the emotional support received from the practice.

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 England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients found it easy to make an appointment. The GP triage system ensured patients were able to access an appointment or receive advice without delay and access to the service was good.

The practice had good facilities and was well equipped to treat patients and meet their needs. All patient areas were accessible for patients in wheelchairs and those with reduced mobility. Information about how to complain was clear and well publicised. Evidence showed that the practice responded quickly to complaints and feedback and learning was always shared with staff and other stakeholders.

Designated teenage clinics and long term conditions clinics such as asthma and diabetes, improved access to the service for patients.

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. Regular meetings were held to discuss issues and progress and ensure good governance. Staff felt confident to raise issues and make suggestions and were committed to the practice vision and values.

Systems used to monitor quality were effective with improvements shown in performance against national and local targets such as Quality and Outcomes Framework QOF. QOF is a national recording system used to monitor the performance of GP services in a number of areas. The patient participation group (PPG) was active and offered practical support and challenge to the service. Staff had received inductions, regular performance reviews and additional training.

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 had been consistently good over the past three years 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. The practice offered proactive, personalised care to meet the needs of the older people in its population and had worked with a care coordinator to ensure continuity of care. It was responsive to the needs of older people, and offered home visits early in the day to ease onward referral if required. The GP telephone triage service ensured older patients could access care and advice when required.

The practice offered single GP cover to local care homes to aid continuity of care and worked with a consultant physician for care of the elderly to review complex cases.

People with long term conditions

Good

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

Practice nurses led clinics for specific long term conditions and a robust system for inviting and following up patients for health check was in place. If patients were unable to attend their review appointment a home visit was offered. QOF data showed the practice consistently performed well above the CCG and England average in relation to indicators in respect of long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease. They achieved 100% of the available points in all of these areas which was above the local CCG and England average.

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Patients who had more complex needs or whose condition was life limiting were regularly discussed at multi-disciplinary team meetings and robust care plans put in place

Families, children and young people

Good

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

Summary of findings

Immunisation rates were high for all standard childhood immunisations when compared to local and national figures. Children and young people were treated in an age-appropriate way and were recognised as individuals.

Staff were aware of and implemented Fraser and Gillick guidelines to ensure that young people were able to give informed consent about their care and their best interests were maintained. . The teenage health clinic helped young people access care and advice in a welcoming environment. We saw evidence that young people valued and regularly accessed this service.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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 had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. For example appointments and prescriptions could be booked online; telephone GP triage was available to reduce the need for patients to attend the practice. Appointments were available up to 7:45pm on Tuesdays. The practice offered a full range of health promotion and screening that reflected the needs for this age group, for example travel vaccinations, family planning, and heart screening.

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 vulnerable patients including those with a learning disability. All staff had attended additional training to help them understand the needs of patients with a learning disability and the practice carried out annual health checks for this group. Longer appointments for people with a learning disability were available. The practice worked with a local charity to offer support to people experiencing domestic violence and staff had received additional training to help facilitate this.

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. Staff knew how to recognise signs of abuse in

Summary of findings

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 care of people experiencing poor mental health (including people with dementia).

People experiencing poor mental health had received an annual physical health check and a counsellor attended the practice once per week. Patients had access to the local mental health service, accessed via the practice. Four partners had attended additional training on the treatment of substance misuse which helped meet some of the needs of this group. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including working with two psychiatrists as part of their work with local care homes.

The practice achieved 100% of the available points for patients with depression and dementia and 99.5% of the available points for patients experiencing mental ill health. This was 5.6 percentage points above the CCG average and 9.1 percentage points above the national average.

Diagnosis and management of patients with dementia had increased following a practice initiated review of high risk patients.

Summary of findings

What people who use the service say

Prior to our inspection we left a comment box and cards for patients to complete. We received 29 completed comment cards. Of those we received 28 had wholly positive comments, expressing views that the practice offered an excellent service with understanding, caring and compassionate staff, and committed, caring GPs.

The national patient survey results from January 2015 showed that 115 patients had taken part. Comments were generally very positive. 91% of patients who responded described their experience of making an appointment as good, (local and national figures were 74% and 73% respectively). Data showed that 93% said the GP was good at treating them with care and concern (local and national figure was 87% and 85%) and 92% described their overall experience of this surgery as good. This was much higher than the local (87%) and national (85%) figures.

We spoke with 15 patients during our inspection, including three members of the PPG. All 15 patients said they were happy with the care they received, and felt the staff were all professional, approachable, and caring.

Areas for improvement

Action the service SHOULD take to improve

- Ensure records of significant event investigations contain all relevant information, including follow up, learning and further investigation.

Kelvingrove 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, and a variety of specialists: including practice manager, practice nurse and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Kelvingrove Medical Centre

Kelvingrove Medical Centre provides primary medical care services to approximately 9,300 patients. The practice is based in a purpose built building in the Derbyshire town of Heanor. There is a smaller branch surgery, in Codnor, near Ripley. We did not visit this during our inspection.

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract supporting the practice to deliver primary care services specifically tailored to the local community or communities.

There are six GPs at the practice, five of whom are partners, and one is a salaried GP. There are three male and three female GP's. The practice is a teaching practice which means GPs in training also see patients. At the time of our inspection there were three GPs in training. In addition the nursing team comprises of four practice nurses and one healthcare assistant.

Kelvingrove Medical Centre has opted out of providing out-of-hours services to its own patients. Out-of-hours services are provided Derbyshire Health United (DHU) through the 111 telephone number.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as part of our regulatory functions. This inspection was planned to check whether the provider is 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

Detailed findings

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 visiting, we reviewed a range of information that we hold about the practice and asked other organisations including HealthWatch to share what they knew. We carried out an announced visit on 14 May 2015. During our visit we spoke with a 13 members of staff (GPs, nursing staff and administration and reception staff) and spoke with 15 patients who used the service. This included members of the Patient Participation Group (PPG). We also spoke with a visiting external service provider. We observed how people were being cared for and talked with patients We reviewed comment cards where patients shared their views and experiences of the service.

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 with 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 significant event meetings where issues were discussed. We saw that staff were proactive in raising significant events and that learning from them was shared with all staff. We found that the practice had reviewed significant events over time to identify any themes or trends.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff used significant event forms to record events and sent completed forms to the practice manager. 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. They showed us the system used to manage and monitor incidents. We looked at several of these significant events and saw they had been investigated in a timely manner and actions had been taken to prevent them from happening again.

The annual review showed that 15 significant events had been recorded between February 2014 and January 2015.

Monthly significant events meetings were held to review these and quarterly whole practice meetings were held where learning from these was shared with all staff. For example, a significant event was raised after a patient with a penicillin allergy was prescribed an antibiotic containing penicillin. The investigation identified that the allergy box on the electronic record had not been checked and the patient had not informed the GP of their allergy. Following this an email reminder was sent to all staff to ensure the allergy box was checked and patient records were updated with any known allergies. There was no evidence of any similar events following this.

We found that whilst all significant events were discussed at partners meetings and at the annual review, some were not always recorded appropriately. We found two records that did not include details of follow up and learning or further investigation. We raised these concerns with the practice who provided assurances and evidence for how they would address this.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were shared with staff and discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. 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 a dedicated GP as lead for safeguarding both vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role, we saw evidence that GPs had been trained to an appropriate level. All other staff had received safeguarding training to a level appropriate to their role and were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a chaperone policy in place at the practice for staff to refer to for support. Signs informing patients of their right to have a chaperone present during any examination were clearly displayed throughout the practice. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing and reception staff had been trained to act as chaperone and had been checked under the Disclosure and Barring Scheme to make sure they were suitable to undertake this role. We spoke

with two members of staff who clearly described to us their role and responsibilities in protecting patients from the risk of abuse and knew what action to take if they had any concerns.

Medicines management

Medicines at the practice were stored securely. The practice had a very robust and well organised system to ensure that refrigerated medicines were in date and stored at the correct temperature. Arrangements were in place to ensure medicines including those in GPs' bags were in date. We saw that patients' repeat prescriptions were reviewed regularly to ensure they were still appropriate and necessary.

The practice had access to support from a pharmacist from the Clinical Commissioning Group (CCG) medicines management team. The Pharmacist told us GP's were always open and available for discussion and queries and that prescribing and medicines management reflected best practice. They also told us they had the upmost confidence in the ability and competence of nurse prescribers at the practice.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw up-to-date copies of all the PGDs and evidence that the practice nurses had received appropriate training to administer vaccines. Additionally the Health Care Assistant (HCA) administered a small number of injections. We saw that PSD (Patient Specific Directives) were attached to all patient files to facilitate this.

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 and kept securely at all times.

Cleanliness and infection control

The practice was visibly clean and tidy and staff followed appropriate infection control procedures to maintain this standard. The practice carried out annual infection control audits and where issues had been identified action had been taken to improve in these areas. Reasonable steps had been taken to protect staff and patients from the risks of health care associated infections. Staff had received relevant immunisations and support to manage the risks of health care associated infections. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice and deliver infection control training to staff. Protected time was allocated to the infection control lead to carry out spot checks on cleanliness and develop action plans to address any issues identified. All staff had received training about infection control specific to their role. 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.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment maintenance logs that demonstrated that all electrical equipment had been tested and maintained regularly. For example, all portable electrical equipment had been tested and medical devices calibrated in December 2014 to ensure they were safe to use.

Staffing and recruitment

The staff rota was planned a month in advance and included annual leave cover. Although there appeared to be sufficient numbers of staff with appropriate skills to keep people safe, staff we spoke with told us they felt they did not have enough staff to carry out their duties effectively when staff were absent on leave or sick.

Staff records we looked at contained evidence which showed that appropriate recruitment checks had been undertaken prior to employment. For example, photographic proof of identification, references from previous employment, qualifications, and registration with the appropriate professional body where required. We saw that the practice had a system in place to monitor the continuous maintenance of this registration. We saw that all staff had up to date criminal records checks through the Disclosure and Barring Service (DBS).

We saw that the practice had a recruitment policy in place which set out the process it followed when recruiting and interviewing clinical and non-clinical staff.

Good

Are services safe?

Monitoring safety and responding to risk

The practice had assessed risks to those using or working at the practice and kept these under review. Patients with a change in their condition were reviewed appropriately. Patients with an emergency, unwell children and people with acute mental health crisis were all seen as soon as possible by a GP. We saw an example during our inspection were a patient experiencing a mental health crisis contacted the surgery, was assessed by the triage GP and given an appointment that morning. The GP triage system minimised the risk of patients with an emergency being turned away.

Annual and monthly checks of the building had been carried out. For example, a fire risk assessment and fire drills for staff; gas safety checks and emergency lighting tests.

Arrangements to deal with emergencies and major incidents

There were emergency procedures and equipment in place to keep people safe. 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 severe allergic reaction) and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff had received cardio pulmonary resuscitation training, and a defibrillator was available, which staff were trained to use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of IT, adverse weather, unplanned sickness and the loss of domestic services. The business continuity plan included important contact numbers for use in the event of the loss of one of these services.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff routinely referred to guidelines from the National Institute for Health and Care Excellence (NICE) when assessing patients' needs and treatments. There was a system in place to inform staff of any changes in the NICE guidelines they used. We saw that practice protocols based on NICE guidelines had been developed for staff to refer to. For example, the management of patients with atrial fibrillation (AF). Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. We saw that the practice had also used NICE guidelines in their analysis of significant events and in carrying out clinical audits.

Practice nurses managed specialist clinical areas such as nurse prescribing, diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, cardiac failure and INR monitoring. International normalized ratio (INR) is used to measure how efficiently a person's blood clots. The test is used for patients taking medicine such as Warfarin.

Care was planned to meet identified needs and was reviewed through a system of regular clinical meetings.

The GPs we spoke with used national standards for the referral of patients to other services. For example, two week wait for patients with suspected cancer to be referred and seen. We saw that the practice was performing in line with or better than both the national and local averages for number of patients referred and treated in two weeks

A partner at the practice was a clinical assistant in dermatology and had worked in the dermatology clinic at the local acute hospital for 11 years As a result of this the practice was able to offer tests and assessments for patients with low risk of skin cancers, including diagnostic biopsies and visual checks. Where the check suggested malignancy or a suspicion of malignancy the patient was referred to specialist secondary care. This had improved outcomes for patients and reduced the number of referrals to specialist services to amongst the lowest in the local area. For example, skin cancer referrals for the practice were 151 per 100,000 patients compared to local 329 and national 435 per 100,000 patients.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and outcomes. This included data for the Quality and Outcome Framework (QOF), clinical audits, and compared its performance against other practices in the Clinical Commissioning Group (CCG). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The practice had performed higher than many other practices in several areas and had achieved 98.6% of QOF points in 2014-2015 which was 3.3% higher than the local average.

The practice showed us six clinical audits that had been undertaken in the last year. Four of these were completed audit cycles where the practice was able to demonstrate the changes resulting since the initial audit. For example, one of the GPs at the practice had reviewed the monitoring and treatment of patients with Coeliac disease, (an disease of the auto immune system which means patients can't eat any foods containing wheat or gluten) Guidance stated patients should receive annual blood checks along with height and weight checks. the second audit showed that improvements had been made to ensure patients were given optimal service. This information was shared with other GPs and discussed at the clinical meeting. Other examples included audits of joint injections, diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and prescribing of non-steroidal anti-inflammatory medicines.

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 electronic 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 was working towards the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support

Good

Are services effective?

(for example, treatment is effective)

needs of patients and their families. The practice had access to two specialised palliative care beds at a local care home which GP's could phone to book as necessary. GP's told us that they visited these patients daily.

Effective staffing

Staff had received training appropriate to their roles, and had protected learning time for on going training. They were supported in attending external courses where required. Continuing professional development for nurses was monitored through appraisals, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice. There was an appropriate skill mix among the GPs with obstetrics, dermatology, surgery and substance misuse amongst the additional qualifications GPs had attained.

All the GPs were up to date with their yearly continuing professional development requirements and all either had 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.

Checks were made on qualifications and professional registrations as part of the recruitment process. Staff were given an induction and further role specific training when they started.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. Regular meetings were held to discuss the needs and treatment strategies of patients with long term conditions; palliative care needs and vulnerable and older frail patients who were at high risk of unplanned hospital admissions. These were attended by other professionals including district and palliative care nurses.

The practice 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 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 responsibilities.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local GP out-of-hours provider that enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals to other services

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 the staff were fully trained on the system.

Consent to care and treatment

All the clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Staff were also aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff had received recent training in the mental capacity act.

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. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

There was a practice policy for documenting consent for specific interventions. We saw that there was a form to obtain informed written consent for minor surgery. An audit had been carried out by one of the GP partners which showed that 70% of patients having joint injections had a record of written consent which was scanned and included in their electronic notes. The follow up audit was due to be completed later in 2015.

Health promotion and prevention

The practice offered new patient health checks, and NHS checks for patients aged 40-75. Advice was available on stopping smoking, alcohol consumption and weight

Good

Are services effective?

(for example, treatment is effective)

management. Patients over the age of 75 were allocated a named GP. The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2013 -2104 showed that performance for all childhood immunisations was at or above the average for the CCG for all age groups. Practice nurses used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition. The practice website contained health advice and information on long term conditions, with links to support organisations.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had a register of patients living with dementia. A CCG audit in 2014 identified that the practice had a diagnosis rate for dementia of 58.9%. The practice reviewed this and in 2015 the diagnosis rate improved to 69%. We saw that all patients living with dementia had care plans in place which were reviewed every fortnight.

The practice's performance for cervical screening uptake was 76.2% which was above the national average of 74.3% but slightly below the local CCG figure of 77.7%. Referral rates for screening for bowel (64.9%) and breast (81.4%) cancers were both well above local CCG (61.4% and 78.5%) and national (58.3% and 72.2%) figures.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 15 patients during the inspection, and collected 29 Care Quality Commission (CQC) comment cards. All the comments were positive. Patients told us the staff were always helpful, professional, caring and treated them with dignity and respect. They said the nurses and GPs listened and responded to their needs and they were involved in decisions about their care. They said that the receptionists were helpful.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey carried out during January-March 2014 and July-September 2014. The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data showed that 95% of respondents said that their overall experience was good or very good and 88% of respondents would recommend the practice to someone new in the area. These results were better than the local clinical commissioning group (CCG) average of 88% and 81% respectively. The practice was above the CCG local average for its satisfaction scores on consultations with GPs and nurses. For example, 91% of respondents said the GP, and 97% said the nurse was good at listening to them. This was above the CCG local average of 90% and 91% respectively.

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. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

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. This prevented patients overhearing potentially private conversations between patients and the reception staff.

Care planning and involvement in decisions about care and treatment

Information from the national patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas. For example, data from the survey showed 90% of practice respondents said the GP was good at involving them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were above the local CCG average of 87% and 91% respectively. Additionally, 92% said the last nurse they saw or spoke to was good at involving them in decisions about their care. This was again above the CCG average of 87%.

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.

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

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 94% of respondents to the national patient survey said the last GP they saw or spoke with was good at treating them with care and concern. This was above the local CCG average of 90%. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. The practice kept registers of patients who needed extra support, such as those receiving palliative care and their carers, and patient experiencing poor mental health.

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

Good

Are services caring?

the various avenues of support available to them. Information for carers was also available on the practice website including, videos, useful documents and links to further support.

The practice had a system in place to support patients known to them who had experienced a recent bereavement. We saw that practical advice about what to do in times of bereavement was available for patients on the practice's website. The practice told us that, where possible, a home visit was made to the bereaved family.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs and future needs of the practice population were clearly understood and systems were in place to address identified needs in the way services were delivered. For example, the practice were working with a consultant physician for the elderly from the local acute hospital, to review patients with complex medical needs, either at the patient's home or in the surgery. The consultant also worked with the local care home.

Additionally all home visits to elderly patients were carried out early in the day to ensure early referral and access to hospital if it is required.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, flu vaccination sessions were extended to cover a whole day, rather than just afternoon sessions. This had helped patients more easily access the clinics.

The practice provided a weekly 'walk in' teenage clinic for patients between the age of 14-19 run by a specialist family planning and sexual health nurse. The clinic offered advice regarding contraception, sexual health, chlamydia screening, smoking and drugs. We saw this clinic was well attended and had encouraged young people to access the service. We were shown an example of a patient in this age group who had attended the clinic to discuss contraception. The patient was assessed as being competent and informed to make a decision (using the Fraser guidelines). The patient felt confident to attend the clinic and had developed a trusting relationship with staff. When they had concerns regarding sexual health they were able to access the clinic without delay and receive treatment.

Tackling inequity and promoting equality

The practice had provided equality and diversity training through e-learning for all the staff. The practice recognised the needs of different groups in the planning of its services.

The practice was situated on the ground and first floors of the building with services for patients provided on both floors. Level access was available to both floors as a large ramp led to the first floor. The waiting rooms were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. The building included electronic entrance doors; disabled toilets and a hearing loop for patients with a hearing impairment. Other doors in the building were wide enough to allow ease of access to people in wheelchairs or those with pushchairs.

The practice population were mainly English speaking but for patients whose first language was not English, staff had access to a translation service to ensure patients were involved in decisions about their care.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday, with extended hours to 8.00pm on Tuesdays and 7.00pm on Thursdays. Appointments were available from 8.30am to 12.30 pm and 1.45pm to 6.00pm daily with extended appointments to 7.00pm on Thursday and 8.00pm on Tuesday. The practice did not routinely provide an out-of-hours service to their own patients but patients were directed to the out of hours service Derbyshire Health United (DHU), when the practice was closed.

The practice provided a GP triage system whereby one GP each day responded to calls form patients between 8:00am and 6:30pm. This GP was able to offer same day appointments, telephone consultations and advice. Patients told us they found this system very useful and staff told us it had reduced demand for appointments and freed up GP time for more complex cases that required face to face consultations.

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 by telephoning the practice. At the time of our inspection patients were able to book appointments online. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

Patients told us they were very satisfied with the appointment system at the practice, stating they could usually get an appointment at a convenient time and with the GP of their choice. This was supported by the national patient survey carried out during January-March 2014 and July-September 2014. This showed that 95% of respondents found it easy to get through on the phone compared with the local Clinical Commissioning Group average of 75% and a national average of 73%. Ninety one per cent of respondents described their experience of making an appointment as good or very good. This was above the CCG average of 74% and a national average of 73%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated person who handled all complaints in the practice. Information on how to complain was in the patient information leaflet and on the practice's website.

We saw notes of a meeting to review all complaints received over the previous 12 months. This showed that nine formal complaints had been made during the last 12 months and all had been responded to in line with the practice's complaints policy. An additional three verbal complaints were also reviewed. We saw that learning from complaints was discussed and shared with all staff. For example a change was made to how patient calls to speak to the GP were handled.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy. The practice vision and values aimed to provide safe effective patient centred care by establishing strong GP relationships with patients and the community

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff told us they were proud to work at the practice and had a sense of ownership for the vision and values.

Governance arrangements

There was a very clear leadership structure within the practice. Staff were clear about their roles and responsibilities and felt supported by the management in these.

The practice had identified lead roles for areas of clinical interest or management. A programme of clinical audits was in place. Four of the six audits we were shown included follow up audits that demonstrated suggested changes to practice had improved health outcomes for patients. From our discussions with staff we found that they looked to continuously improve the service being offered, and valued the learning culture.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor quality and identify risk. Data from the Quality and Outcomes Framework (QOF) showed the practice was performing at or above national standards. The practice regularly reviewed its results and how to improve.

Leadership, openness and transparency

Staff we spoke with were positive about working at the practice. They told us they felt supported to deliver safe, effective and responsive care. Staff described the culture at the practice as open and transparent. The GP partner's valued partnership working and recognised the strength of having a strong, cohesive staff team.

Regular practice and departmental meetings were held at the practice and staff felt confident to raise any issues or concerns at these meetings. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Seeking and acting on feedback from patients, public and staff

There was an active patient participation group (PPG) at the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with three PPG members. They told us they felt involved with the practice and listened to. Notes showed the practice staff including GP's attended PPG meetings and questions were responded to. The PPG members told us they had carried out a survey of patient's experiences of the flu clinics. We saw that an action plan was developed from this which included extending the timings of the clinic to include morning as well as afternoon clinics.

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 with colleagues and management and that they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff told us they were able to ask for additional training for their role.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Annual appraisals had been carried out and staff had identified learning objectives and training needs.

The practice was a training practice and supported medical students and GP registrars. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. The practice had completed reviews of significant events and other incidents, and shared these with staff at monthly significant event meetings and team meetings.