

# Darley Dale Medical Centre

## Quality Report

Two Dales  
Darley Dale  
Matlock  
Derbyshire  
DE4 2SA

Tel: 01629 733205

Website: [www.darleydalesurgery.co.uk](http://www.darleydalesurgery.co.uk)

Date of inspection visit: 1 November 2017

Date of publication: 05/01/2018

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

### Summary of this inspection

Overall summary	2
The six population groups and what we found	4

### Detailed findings from this inspection

Our inspection team	6
Background to Darley Dale Medical Centre	6
Detailed findings	8

## Overall summary

### Letter from the Chief Inspector of General Practice

**This practice is rated as good overall.** (At the previous inspection undertaken in October 2014, the practice received a good overall rating, with an outstanding rating for providing responsive services)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Darley Dale Medical Centre on 1 November 2017. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider 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.

At this inspection we found:

- The partners invested high levels of funding in their practice team to provide sufficient capacity, and ensure there was adequate and trained administrative support to relieve pressures on clinical time.
- There was strong clinical leadership and we saw how this impacted positively upon the quality of the service. For example, the GP prescribing lead had overseen cost effective prescribing, and lower rates of antimicrobial prescribing.
- The practice had a live strategy which focussed on the new challenges faced by general practice. This was supported by the appointment of a strategic business manager, and a new premises development to provide an environment to respond to local patients' needs.
- We spoke with community based health, social and care home staff who overwhelmingly provided us with positive feedback about their interactions with the

# Summary of findings

practice team, In particular, we observed that the relationship with social care was driving responsive and compassionate care for patients, including keeping those at risk from harm safe.

- The practice had received the Derbyshire Dignity Award in 2013 and continued to aspire to maintain this achievement. At the time of our inspection, the practice had submitted an application to the county council as part of the biennial renewal which focused on their work with local care homes.
- Results from the latest national GP patient survey showed that the practice had performed above local and national averages in the majority of the questions about patient experience. This was particularly evident in relation to GP access and comments regarding being cared for in a dignified and respectful manner.
- Patients who responded that they were satisfied with the practice's opening hours was marginally below the local and national averages. The practice was proactively looking to address this via a collaborative approach with other practices to implement an 8am-8pm hub service locally.
- The practice encouraged and supported staff to report incidents and near misses. When incidents did

happen, the practice learned from them and improved their processes. Positive events were also recorded in recognition that sharing best practice was an equally valid means of learning, and a way to celebrate success.

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Care planning was embedded within the practice to reflect individual's patients' needs and their own wishes. We saw that 8% of patients had at least one care plan in place at the time of our inspection.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. Staff training records were up to date, and regular appraisals encouraged development at all levels.
- The practice had an established quality improvement programme. This included involvement in research.

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

# Summary of findings

## The six population groups and what we found

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

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

## Summary of findings

# Darley Dale 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, a practice nurse specialist advisor, and a second CQC inspector

## Background to Darley Dale Medical Centre

Darley Dale Medical Practice ([www.darleydalesurgery.co.uk](http://www.darleydalesurgery.co.uk)) is registered with the CQC as a GP partnership with four GP partners. The practice has a population of approximately 8000 registered patients, the majority of whom are over the age of 45. The practice has a higher proportion of patients aged 65 and above in comparison to local and national averages.

The surgery provides primary care medical services commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The practice covers a predominantly rural area and lies north of Matlock within the Derbyshire Dales district.

The premises have a main site within Darley Dale with two branch surgeries situated in the nearby villages of Winster and Youlgreave. The premises at Darley Dale are approximately 30 years old and offer limited opportunities for expansion, and the provider has started building a new practice in the same vicinity which is expected to be completed by September 2018.

The main site is located at 2 Columbell Way, Two Dales, Darley Dale, Matlock, Derbyshire. DE4 2SA. The branch sites are Winster Surgery, Leacroft Road, Winster, Matlock, Derbyshire. DE4 2DL; and Youlgreave Surgery, Alport Road, Youlgreave, Bakewell, Derbyshire. DE45 1WN.

As part of our inspection, we visited the main site and one of the branch sites (Youlgreave Surgery). The practice offers dispensing services from the two branch sites to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy.

The practice team consists of the four GP partners and four salaried GPs (two males and six females). One of the salaried GP is part of the GP retention scheme which aims to offer greater flexibility to support GPs to remain in practice, for example, by working a set number of sessions each year). There are five practice nurses, one of whom works as the nurse manager and three healthcare assistants. In addition, there is also an advanced nurse practitioner who works as a locum, but provides regularly input at the practice for two days each week. The clinical team is supported by a strategic business manager and operations assistant. Each of the three surgeries has a designated lead manager with a team of fourteen reception and administrative staff working across the three sites (some roles incorporate combined duties such as working as a phlebotomist or dispenser). Both branches have a practice dispensary with an identified dispensary manager. The practice employs an audit facilitator and a care coordinator. Two cleaning staff who work at the branch sites are also directly employed by the practice.

The provider is a teaching GP practice and accommodates GP registrars and F2 doctors. There was one GP registrar and one F2 doctor working at the practice at the time of our

## Detailed findings

inspection. A GP registrar is a qualified doctor who has chosen to specialise in general practice, and a F2 doctor is a recently qualified doctor who has yet to decide on their preferred specialty.

The practice serves a relatively affluent population, and is ranked in the second lowest decile for deprivation.

The practice opens from 8am until 6.30pm Monday to Friday, with extended opening hours on a Tuesday morning

from 7.15am, and until 8pm on a Wednesday evening. Scheduled GP appointment times are available each morning and afternoon, apart from on one afternoon most months when the practice closes for staff training. Extended hours GP appointments are available every Tuesday morning from 7.30am until 8.30am and on a Wednesday evening from 6.30pm until 7.30pm.

# Are services safe?

## Our findings

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

### Safety systems and processes

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

- The practice conducted safety risk assessments, including those for fire, Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings), and general health and safety issues. It had a range of safety policies which were regularly reviewed and staff received safety information as part of their induction and ongoing training programme.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. All staff received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns.
- The practice team worked with other agencies to support and protect patients from abuse, neglect, discrimination and breaches of their dignity and respect. We saw clear evidence of effective working with community based health and social care staff to achieve this aim. The practice had forged a strong relationship with social care, and we heard how this impacted positively upon patient care and safety. For example, we were informed that a joint visit was undertaken by a GP and the social worker in the late evening in response to concerns about the welfare of a vulnerable adult. The visit ensured that the individual received support and was moved to an appropriate place to protect their safety as a result of the prompt actions taken by the GP and social worker.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. Regular audits were undertaken and any follow up actions that were identified were addressed promptly.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems in place to support the safe management of healthcare waste.

### Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Reception staff had access to urgent care guidelines for patients who may be presenting with chest pain, stroke or sepsis. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. A training session had been arranged for clinical staff about sepsis later in the year.

### Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- We reviewed a sample of referral letters and these included all of the necessary information.
- The practice had systems to ensure that any urgent incoming patient documents and pathology results were seen by the duty doctor, whilst routine



# Are services safe?

correspondence was actioned within 48 hours. Additionally, there was close scrutiny of all pathology requests requested, and if no results were received back into the practice this was followed up by a GP.

## Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. There was evidence of actions taken to support good antimicrobial stewardship. We observed that the practice was amongst the best within their CCG in terms of prescribing performance. For example, they were in the top four of 35 practices for low levels of antibiotic prescribing. New registrars received training in the prescribing of antibiotics as part of their induction. One GP partner acted as the prescribing lead and was an active member of the local Joint Area Prescribing Committee, and this ensured the practice was updated and adhered to high quality prescribing. The practice also performed highly with regards to cost effective prescribing with a 5% underspend achieved for the previous year.
- The practice had a robust and safe process to ensure any patients being prescribed high-risk medicines were being monitored closely. This was complimented by monthly patient computer searches undertaken by the practice audit clerk to review that necessary monitoring was up to date and adhered to guidance.
- The practice involved patients in regular reviews of their medicines. Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately.
- The practice kept prescription stationery securely and monitored its use. There was a protocol in place for the safe management of controlled drug prescriptions. Staff adhered to a repeat prescription pathway developed by the practice to ensure any repeats requested were only issued with correct authorisation. Uncollected prescriptions were reviewed each month and patients were followed up when this was necessary to make sure they had access to their prescribed medicines.

- Arrangements for dispensing medicines at the two branch sites kept patients safe. We observed that one site did not have a lockable door to prevent unauthorised access to the dispensary area, although the room was always occupied. However, the practice arranged to fit a digilock to this door following our inspection to enhance security.

## Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events, incidents and near misses. Positive events were reported in recognition that learning from success was equally as important to drive improvements in quality.
- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so, and encouraged a low threshold for reporting. This resulted in high reporting and we saw that a total of 38 events had been recorded in the last year, 13 of which were near misses.
- There were effective systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, we saw that systems to check patient identifiers had been strengthened further to an incident when a letter was scanned into the wrong notes, as two patients had the same name. This was addressed by training staff to check three specific identifiers to ensure the correct person was selected. Alerts were also added to the records to highlight to staff that there were other registered patients with the same name. An annual review of incidents was discussed with the practice team to review any recurring themes.
- There was a system for receiving and acting on patient and medicine safety alerts. There was a practice policy to support the dissemination and response to incoming alerts. We saw evidence that when medicines alerts were received, searches were undertaken to identify patients this might affect, and these were then followed up and reviewed accordingly.

# Are services effective?

(for example, treatment is effective)

## Our findings

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

### Effective needs assessment, care and treatment

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

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. There was extensive use of individualised care planning with 729 active care plans in place for patients at the time of our inspection.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

#### Older people:

- Weekly multi-disciplinary meetings reviewed the ongoing care and support for patients who were at risk of hospital admission or had complex health and care needs. We observed that the practice team worked effectively with community based staff as part of an integrated approach to care.
- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs, including a review of medication.
- The practice employed their own care co-ordinator and followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any new or additional needs.

#### People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. Where patients had one more than one condition, they were seen as part of one recall appointment, rather than have to attend more than once. Some groups, such as patients with asthma, were targeted opportunistically to increase the uptake of

reviews. The practice provided information that showed the practice had achieved a good uptake for annual reviews for example: asthma (73%); chronic obstructive airways disease (91%); diabetes (93%); and hypertension (82%). For patients with the most complex needs, the GP worked with other health and care professionals, including specialist nurses, to deliver a coordinated package of care.

- Staff who were responsible for reviews of patients with long term conditions had received specific training in support of this.

#### Families, children and young people

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice provided emergency contraception, and offered family planning services.
- Monthly meetings were held with the health visitor to review any children where there were any known safeguarding concerns. GPs contributed to requests for child protection case conferences and the multi-agency risk assessment conference (MARAC), where information is shared on the highest risk domestic abuse cases between representatives of local agencies such as the police, health and social care providers.
- The health visitor offered child development reviews across the three sites if parents had transport difficulties in attending one of the regular local venues, or if a meeting at the surgery offered other benefits, for example, by having access to the practice team.
- Teenagers were signposted to support services if they encountered emotional difficulties.

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

- The practice's uptake for cervical screening was 82%, which was in line with the local average of 84% and national average of 81%. This was achieved with low exception reporting rates of 1% (3% below local and 6% below national rates). This outcome contributed to the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

# Are services effective?

## (for example, treatment is effective)

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There had been a total of 172 checks completed in the last 12 months. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- The practice had forged a strong working relationship with social care, and we heard how this impacted positively upon patient care and safety. For example, we were informed that a joint visit was undertaken by a GP and the social worker in the late evening in response to concerns about the welfare of a vulnerable adult. The visit ensured that the individual received support and was moved to an appropriate place to protect their safety as a result of the prompt actions taken by the GP and social worker.
- The practice attended the local Vulnerable Adult Risk Management (VARM) meeting to facilitate effective multi-agency working around vulnerable adults deemed to be at risk of serious harm.
- End of life care was delivered in a coordinated way with extensive collaboration from the multi-disciplinary team via weekly meetings and regular communication in-between. The care provided took into account individual needs such as the patients preferred place of care.
- The practice conducted an 'after death analysis' of all patients each month and reviewed this annually to consider any learning. A review of deaths over a 12 month period up to August 2017 showed that 86% of expected deaths occurred in the patient's preferred place, and 87% of patients had been prescribed anticipatory medicines. The identified learning was to highlight that end of life care was reviewed by a GP at the earliest opportunity following a hospital discharge to ensure all arrangements could be put in place as soon as possible to support a dignified death.
- The practice held a register of patients with a learning disability. The practice had completed annual health reviews for 91% of their 23 patients on this register, which was higher than local and national averages.
- The practice had undertaken an audit of cancer screening uptake for patients with a learning disability in March 2017. This had identified those that were

eligible and those who had been tested. The practice continued to actively encourage screening as part of the annual review and easy read information was available for patients to promote the service.

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

- A mental health team worker had attended multi-disciplinary meetings to discuss patients requiring mental health support. At the time of our inspection this had temporarily ceased due to the previous worker having recently left their post.
- 77% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was slightly lower than the local average of 83% and national average of 84%. Exception reporting rates were in alignment with averages.
- 86% of patients with a new diagnosis of dementia recorded in the preceding year had a record of recommended investigations recorded between 12 months before, or 6 months after, entry onto the practice register. This was in line with the national average and just below the CCG average (91%), although exception reporting rates were significantly lower at 3% than local (18%) and national averages (22%).
- 91% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was comparable to the local and national averages. Exception reporting rates were higher at 24% (8% above the CCG average, and 11% above the national average).
- The practice considered the physical health needs of patients with poor mental health and those living with dementia. For example, 91% of patients experiencing poor mental health had received discussion and advice about alcohol consumption in the last 12 months (CCG 94%; national 91%).

### Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, in October 2017, the practice performed an audit which identified that 15% of care home patients had not received/been offered the pneumococcal vaccine. They then acted to review these patients and offer the vaccination to keep them safe.

# Are services effective?

## (for example, treatment is effective)

The most recent published Quality Outcome Framework (QOF) results for 2016-17 were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 99% and national average of 96%. The overall exception reporting rate was 8% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

We noted that exception reporting rates for indicators relating to mental health indicators were generally higher than local and national averages. However, the practice had identified this them as a coding issue which had since been corrected.

- The practice was actively involved in quality improvement activity, and was able to provide a timetable of their programme since 2015. This included audits (which also incorporated the two dispensaries); reviews of NICE guidance; and actions taken in response to safety alerts. The practice provided us with examples of completed clinical audits which included a full cycle audit on the monitoring of patients with prostate cancer. The second cycle audit demonstrated that all patients were being appropriately monitored by the practice in accordance with recommended guidance. In addition, it did highlight three patients requiring a follow up within secondary care which had not been completed, and the practice contacted these patients to ensure they received this review.
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had an active involvement in research programmes. They had recently participated in the 'FAST' trial to assess the effectiveness of a new medicine for gout. The practice helped recruit patients to the trial and liaised with researchers if there were any issues relating to recruited patients. In addition, involvement in the 'CANDID' study looked at helping to predict likelihood of cancer with a patient's presenting symptoms to aid earlier cancer diagnosis in primary care.
- The practice employed a part time audit clerk to facilitate quality improvement work.

### Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained and monitored via the practice intranet's alert system. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, regular meetings, appraisals, clinical supervision or one to one support as appropriate (for example, for one nurse who was an independent prescriber) and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice had invested in high staffing levels in recognition that this was essential to provide quality and continuity. Staff were trained to upskill them to undertake some administrative tasks that would have previously been allocated to clinicians.
- The practice supported apprentice posts, some of whom who had gone on to secure substantive employment with the practice. The practice received the small employer of the year award in recognition for its work with apprentices.
- GP locums were sourced from those who had previously worked at the practices or had undertaken a placement there as a GP registrar. This ensured familiarity with systems and continuity for patients and staff. The practice had developed a comprehensive information pack for locum GPs and new GPs.

### Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice employed their own care

# Are services effective?

(for example, treatment is effective)

co-ordinator to help facilitate this. We saw that the practice worked with patients to develop personal care plans and observed examples which showed the plans were comprehensive and up to date. Information was shared appropriately with out of hours' and other relevant providers to ensure a smooth transition across services for patients.

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

## Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.

- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, there was access to smoking cessation and weight management advice on site with regular visits from the Live Life Better Derbyshire Service.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

## Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Care home staff told us that GPs assisted in best interest assessments for their residents when this was appropriate.
- The practice monitored the process for seeking consent appropriately. For example, we viewed an audit of minor surgery that demonstrated 100% compliance with written consent.



# Are services caring?

## Our findings

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

### Kindness, respect and compassion

Patients told us that staff treated them with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. This was evidenced by up to date staff training in equality and diversity.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All three patients we spoke with on the day of the inspection and almost all of the 89 Care Quality Commission patient comment cards we received, were positive about the service experienced. Four cards contained a negative comment relating to access to appointments and delayed diagnosis. The results of the NHS Friends and Family Test were consistently positive and we reviewed the returns over the preceding three months which showed that 17 of 19 respondents would be 'extremely likely' to recommend the service with the other 2 said that they were 'likely'. The national GP survey results from July 2017 indicated that 90% of respondents would recommend this surgery to someone new in the area, compared to the CCG average of 81% and national average of 77%.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 221 surveys were sent out and 119 were returned. This represented about 1.5% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 98% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 96% of patients who responded said the GP gave them enough time; CCG - 88%; national average - 86%.

- 98% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 96% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 89%; national average - 86%.
- 92% of patients who responded said the nurse was good at listening to them; (CCG) - 94%; national average - 91%.
- 97% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 98% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 94%; national average - 91%.
- 92% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

Overall the survey results were higher than CQC or national averages.

### Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, communication aids (such as a hearing loop) and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers, and the list was reviewed on a regular basis to ensure it was kept updated. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 166 patients as carers (just above 2% of the practice list).

## Are services caring?

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.
- A practice Carers Protocol had been developed. This included the identification of carers, for example, by providing a carers referral form to anyone collecting a prescription on a patient's behalf.
- The practice had undertaken work to specifically identify young carers although none were found at the time this was done.
- Staff told us that if families had experienced bereavement, either a member of the practice team or the wider community health team, contacted the family or carer. This call was either followed by a patient consultation (if required) and/or by giving them advice on how to find a support service.

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

- 90% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 90% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 85%; national average - 82%.
- 93% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 93%; national average - 90%.
- 90% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

### Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- There was a lead GP within the practice to promote dignity.
- The practice had received the Derbyshire Dignity Award in 2013 which has to be re-applied for every two years. It was one of only five practices in Derbyshire to hold the award. For 2017, the practice presented a care home project to demonstrate their ongoing adherence to high quality caring standards. This involved the allocation of a named GP for each home with regular scheduled visits, with protected time for advance planning to incorporate the patient's wishes and views of families and carers including best interest decisions. Each patient had a written care plan which was shared with the out of hours' provider to enable individualised care that was in alignment with the patient's wishes. Patients were seen within their own rooms to allow privacy, and were allocated sufficient time to allow for a dignified conversation. Family members could be seen either at the home, at the surgery, or consulted with by telephone, and contributed to best interests decisions when required.
- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998, and all staff were up to date with training in information governance. One GP was identified as the Caldicott Guardian (this is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing)

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

### Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, and advanced booking of appointments.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. A poster in reception provided information to patients to show that the practice would strive to provide them with the information they required in the format that they required, for example, in larger print. The practice were able to describe how they accommodated individual needs, this included an example of a patient who was profoundly deaf.
- The practice had access to a 'consultant connect' scheme which gave a direct phone line to consultant at the nearest acute hospital and this service was available for haematology, gastroenterology, paediatrics and gynaecology. Access to timely expert advice helped to avoid unnecessary referrals or admissions to hospital.
- Patients could be referred through to a single point of access for community hospital admissions or to access urgent community rehabilitation or social care to support patients at home.
- The practice produced a comprehensive quarterly newsletter containing local news and health information. The latest edition including information on local services available to help people to stop smoking, advice about providing accessible information to registered patients in a format that met their specific communication requirements, and details of a forthcoming carers' event.
- A machine was provided for patients to check their own blood pressure and record the results which were then handed into reception. This had helped to identify some patients who then required follow up from a clinician.
- The Citizens Advice service provided sessions at all three practice sites. A report produced by this service for 2015-16 demonstrated that 72 practice patients had been helped with access to benefits and grants.

### Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- An advanced nurse practitioner worked at the practice for two days each week on a locum basis. This input allowed GPs to undertake home visits earlier in the day and thereby arrange any support services indicated more quickly, thereby reducing the necessity to admit the patient into a hospital.
- Patients were referred via the voluntary sector Single Point of Access (vSPA) which connects health & social care professionals to voluntary sector providers through a clear and easily accessible pathway. For example, befriending services to help support isolation
- Appointment reminders were sent to older and vulnerable patients, and these patients would be called if they did not attend for either a practice or hospital appointment.
- If patients received their medicines from the practice's dispensaries, these were delivered to the patients homes if they were unable to collect them.
- The practice provided care for residents at four local care homes. Fortnightly visits were made to the home by a named GP and any urgent requests were responded to on the day. We spoke to managers at three of these care homes who informed us that their residents received an excellent service from the practice. They told us that residents received continuity in care and were always treated with dignity and respect. GPs took time with patients and participated in best interest assessments and advance planning arrangements whenever necessary. They told us that as well as the



# Are services responsive to people's needs?

## (for example, to feedback?)

GPs, the healthcare assistant visited the home to take bloods and the care co-ordinator held regular reviews at the homes. One manager told us how the care co-ordinator had worked with them to streamline information in care plans between the practice and the home. Quarterly management reviews were also held to discuss how the service was operating and to consider any improvements.

- The practice provided primary care support to the community bed wards at community hospitals based in Matlock and Ashbourne. This involved two ward rounds at each site every week when a GP would review each patient with the ward's advanced clinical practitioner. GPs would also take phone calls or make ad-hoc visits if needed. The practice utilised beds at Matlock for their own patients, particularly to avoid unnecessary district hospital admissions, provide locally based hospital care or support end of life care for those patients not managing at home. This allowed continuity for patients following their care through hospital.

### People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings and worked with community based teams to discuss and manage the needs of patients with complex medical issues.
- The practice provided insulin initiation on site for appropriate patients with diabetes
- The practice worked closely with specialist nurses, for example, community heart failure nurses, to provide expert advice for those patients that required it.

### Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All children were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours appointments were available.
- Access to GP appointments was monitored continuously to deliver a maximum of one week's wait for a routine appointment, and two weeks' wait to see a named clinician.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- In response to an identified higher number of dermatology referrals, a GP had led the development of a new dermoscopy service (an examination of the skin with magnifying equipment). This ensured a more local service for patients and a reduction in inappropriate referrals. An audit of the service was planned for January 2018 to assess the impact this had achieved.
- A GP offered a musculoskeletal service on site which included joint injections.
- The practice offered a range of services which included travel vaccinations (including Yellow Fever), family planning, blood tests, 24 hour blood pressure monitoring, smoking cessation, spirometry (a test used to help diagnose and monitor certain lung conditions), Doppler tests (to help detect abnormal flow within blood circulation), and electrocardiogram (an ECG is a simple test that can be used to check a patient's heart's rhythm and electrical activity).

### People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice provided input to two local community hospitals and delivered two regular ward rounds on site each week, as well as responding to any urgent needs in-between.
- The practice had a named GP for each of the four care homes they were allocated. The named GP visited the home every fortnight, and the practice responded to any urgent issues as required.
- The practice welcomed people living in vulnerable circumstances, such as homeless people or those who had been relocated due to domestic violence, to register with the practice.

# Are services responsive to people's needs?

## (for example, to feedback?)

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

- One GP was a section 12 approved doctor (this is a doctor recognised under section 12(2) of the Mental Health Act as having specific expertise in the diagnosis and treatment of mental disorder). This included assessments for patients as part of Deprivation of Liberty Safeguards (DoLS) which aims to ensure that people in care homes or hospitals are looked after in a way that does not inappropriately restrict their freedom. This role brought additional expertise on the management of mental health conditions to the practice.
- The practice had dementia friendly status and the practice team had a good understanding of how to support patients with mental health needs and those patients living with dementia. We observed that all but one member of the practice team staff had up to date training in the mental capacity act and DoLS, and training was booked for the remaining staff member for the week following our inspection.
- The Alzheimer's Society had been involved a review at the practice and this had resulted in some changes to benefit those with dementia such as making the names posted on doors available in larger print.
- A quick reference guide for adult mental health resources had been developed within the practice for clinicians to enable effective signposting to support services.

### Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 221 surveys were sent out and 119 were returned. This represented 1.5% of the practice population.

- 75% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 95% of patients who responded said they could get through easily to the practice by phone; CCG - 72%; national average - 71%.
- 96% of patients who responded said that the last time they wanted to speak or see a GP or nurse; they were able to get an appointment; CCG - 86%; national average - 84%.
- 92% of patients who responded said their last appointment was convenient; CCG - 84%; national average - 81%.
- 86% of patients who responded described their experience of making an appointment as good; CCG - 73%; national average - 73%.
- 78% of patients who responded said they don't normally have to wait too long to be seen; CCG - 64%; national average - 58%.

On the day of our inspection, we saw that a routine GP appointment could be booked within one week, and advanced bookings to see a GP could be made up to two months ahead.

### Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The practice's complaint policy and procedure was in line with recognised guidance. Six complaints were received in the last year which we reviewed and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, where the outcomes from two separate consultations had not identified a patient's presenting condition, the GPs reviewed their intervention and updated their knowledge in line with current NICE guidance.

# Are services well-led?

Good 

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

## Our findings

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

### Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy. Clinical leadership was directed by GPs undertaking specific lead responsibilities such as prescribing, QOF and safeguarding.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The practice had appointed a strategic business manager earlier in 2017 in recognition of the changing nature of general practice and the requirement to adapt from the traditional practice management role.

### Vision and strategy

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

- There was a clear vision and set of values, which were displayed within the practice,
- The practice developed its mission statement and values jointly with staff.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The practice had a 'live' strategy which was in line with health and social priorities across the region. This was in alignment with the NHS Five Year Plan, and the practice development was in line with five of the ten high impact areas by managing workload more effectively to allow clinicians to focus on their roles.

- The practice planned its services to meet the needs of the practice population as demonstrated by the development of a new purpose built practice for Darley Dale.
- The practice had invested in the practice team with higher numbers of staff in comparison to many other similar sized practices. The costs were partially met by the partners undertaking wider roles generating income which was reinvested into the practice.

### Culture

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

- Staff stated they felt respected, supported and valued. They told us that they enjoyed their work and were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. We saw evidence to confirm this when reviewing incident reports
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. All staff received regular annual appraisals in the last year, including salaried GPs. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was an emphasis on the safety and well-being of all staff.
- Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams. Team members from across the three sites undertook an annual weekend walk. These were usually well attended and helped promote team building.

### Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.

# Are services well-led?

Good 

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There was a schedule of regular in-house meetings
- Some of the GP partners held strategic lead roles within the clinical commissioning group (CCG) which helped influence and drive improvement in the delivery of patient care within the locality.

## Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. This was supported by a practice intranet system which included alerts to ensure that review dates were scheduled and acted on.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.

## Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

## Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, as part of the development of the new practice building at Darley Dale, patients were consulted with regards to two potential site options, and the practice selected the one which was most popular with patients.
- There was an active patient participation group. We spoke with a member of the PPG who informed us that the PPG had quarterly meetings with practice representatives. The PPG representative told us that the group was treated respectfully and was listened to by the practice. The practice was open with them when things had gone wrong and that they were consulted on issues that impacted upon patients, for example the relocation of the main site and changes to the appointment system.
- The practice analysed patient survey data and considered any areas that could be improved. For example, the practice was looking at a hub service to be available for patients between 8am and 8pm. Practice patients were consulted about a preferred location for the new site at Darley Dale.

## Continuous improvement and innovation

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

- The new build at Darley Dale was in progress with a view to relocate in September 2018. This had been planned as part of a five year project to meet local demands from new housing developments, and to respond to the

# Are services well-led?

Good 

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

changing face of primary care by offering more and new services closer to patients' homes. This had involved effective collaboration with other providers and commissioners.

- There was a focus on continuous learning and improvement at all levels within the practice. For example, the practice had developed a bid to provide

GP services between 8am-8pm Monday-Friday. This was being done as part of a collaborative approach to secure engagement from other local practices as part of a single hub.

- The practice participated in a local 'Physio Assist' pilot to support those patients struggling to access physiotherapy. This web-based system aimed to improve the quality of patient information and advice to help patients manage their condition.