Dr A Palmer & Dr J Gardner

Quality Report

Barlborough Medical Practice
The Old Malthouse
7 Worksop Road
Barlborough
Chesterfield
Derbyshire
S43 4TY
Tel: 01246 819994
Website: www.barlboroughmedicalpractice.co.uk

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
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 Dr A Palmer & Dr J Gardner on 9 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. It was also good for providing services for all population groups we inspected (older people, families, children and young people, people with long term conditions, working age people (including those recently retired and students, people whose circumstances make them vulnerable and people experiencing poor mental health including people with dementia). It required improvement for providing safe services.

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

- Patients overwhelmingly praised the practice staff for an excellent and person centred service.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Some patients commented that they found it difficult to get through to the practice by telephone in the morning; however the majority of patients said that there was good access to the practice. Urgent appointments were available the same day.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and further training needs had been identified and planned.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were systems in place for recording, monitoring and reviewing information about safety and safeguarding.

Summary of findings

- The practice took a proactive approach to working with other organisations and local practices in planning service provision for patients. This included the delivery of coordinated care in liaison with the community support team.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand.
- 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.

We saw one area of outstanding practice:

- Patient feedback was overwhelmingly positive about the way staff treated people and most patients confirmed they had consistently received an excellent and caring service. This was corroborated by positive patient survey results from different sources and external professionals we spoke with.

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

The areas where the provider must make improvements are:

- Ensure a risk assessment is in place and / or a Disclosure and Barring Service (DBS) check has been received before any member of staff can undertake chaperone duties.

In addition the provider should:

- Ensure systems in place for recording significant events and safeguarding discussions in respect of children are strengthened to give a clear and accurate picture of safety and information discussed.
- Ensure completion of e-learning by staff is actively monitored to assure the provider that staff have completed relevant training in a timely way.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

Risks to patients were mostly assessed and well managed. Risk assessments and / or criminal record checks through the Disclosure and Barring Service (DBS) had not been completed for non-clinical staff who carried out chaperone duties. We were however; assured after our inspection that these checks were in progress and staff would not undertake chaperone duties until the checks had been completed.

The practice had systems in place for recording significant events and safeguarding discussions. However these needed to be strengthened to give a clear and accurate picture of safety.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Staff told us lessons were learned and communicated widely to support improvement.

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. This included a system to highlight children subject to protection plans and multidisciplinary working with the community support team, health visitor and midwife.

Feedback from four professionals working with the practice was positive in respect of collaborative working with the practice to ensure patients were kept safe.

Appropriate arrangements were in place for recruitment of staff, monitoring of infection control practices, medicines management and dealing with emergencies. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Nationally reported data showed some patient outcomes were above and others slightly below average for the locality. Overall, the practice had achieved a total of 99.1% for its 2014/15 Quality Outcomes Framework (QOF) performance. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

Summary of findings

Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Patient feedback was positive in respect of the quality of clinical care provided.

Staff had received training appropriate to their roles and most training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to proactively improve patient outcomes and share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients expressed a high level of satisfaction with the quality of care they received and felt emotionally supported when needed. This was an outstanding feature we found. Patient's said they consistently received a caring and excellent service and this was confirmed by patient survey results and data reviewed.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The practice team felt strongly that they offered caring, personalised and patient centred service.

We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Staff demonstrated a commitment to offer kind and compassionate care and maintained patient confidentiality. Views of external stakeholders such as care home providers and health professionals were very positive and aligned with our findings.

The patient survey results published in January 2015 showed that patients rated the practice higher than others for some aspects of care. Eighty-six percent (86%) of practice respondents described their overall experience of this surgery as good. Satisfaction scores on consultations with GPs and nurses were comparable to the clinical commissioning group (CCG) averages.

Suitable care planning arrangements were in place to ensure patients received appropriate care and treatment. Information about the services available for carers and patients was easy to understand and accessible.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and North Derbyshire clinical commissioning group (CCG) to secure improvements to services where these were identified.

The practice's multi-disciplinary working was integral to the delivery of person centred and coordinated care for its patients. Key focus areas included avoiding unplanned admissions and ensuring good care for the frail and elderly. The practice also acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG).

Patients said they were able to access care and treatment when they needed it. They found it easy to make an appointment with a named GP or GP of choice and 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity which were accessible to staff. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients, which it acted on. There was a high level of staff satisfaction. Staff had received inductions, regular performance reviews and attended staff meetings and events. The patient participation group (PPG) was active and was actively encouraged to be involved in shaping the service delivered at the practice.

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.

The practice had 415 patients aged 75 and over, and all of them were allocated a named GP to ensure continuity of care. Data reviewed showed 98% of patients had received a check in the last 12 months. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.

We saw good examples that showed the community matron and care coordinators (both employed by the practice) had a key role in coordinating the care of frail and elderly patients within their own home. Feedback from patients who had experienced this service was strongly positive.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. This included weekly community support team meetings attended by Macmillan nurses, district nurses and social care staff. Feedback received from two care home managers confirmed excellent working relationships with the practice and regular review of patient's health care needs.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and avoiding unplanned admissions. It was responsive to the needs of older people and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Patient feedback was strongly positive about the quality of care provided. Patients confirmed that staff were caring and responsive to their care needs. Several examples were given of where specific staff had gone above and beyond to ensure they received appropriate diagnosis, treatment and care within a timely period. This included facilitating an appointment with the nurse outside of opening hours and follow-up calls to check on their wellbeing.

The practice had 939 patients listed on its long term condition register. All these patients had been offered an annual health check in the last 12 months and 92.5% of these had received a check. All these patients had a named GP and a structured annual review to

check that their health and medication needs were being met. The named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care for patients with the most complex needs.

Nursing staff had lead roles in chronic disease management and provided a range of clinics for conditions such as asthma and heart disease. Clinics were devised around the needs of the patient's (and not specific days and times) to ensure flexibility and choice. The practice promoted self-management for conditions such as diabetes and asthma; and through collaborative working worked to ensure that care was delivered in the community.

Patients at risk of hospital admission were identified as a priority and discussed at the weekly community support team meeting. Appropriate care planning arrangements were in place. Longer appointments and home visits were available when needed.

Families, children and young people

Good

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

Patients told us children and young people had access to same day appointments, were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

Staff actively provided parents with the "when should I worry" leaflet to increase understanding and management of respiratory tract conditions (coughs, colds, sore throat and ear aches) common in children. School age children, particularly those with a diagnosis of asthma, were encouraged to share their asthma plan with their school to ensure they received appropriate when needed.

There were systems in place to identify and follow up children living in disadvantaged circumstances and those who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.

The practice website had a section on teen health with useful information on health and sexual health promotion. A full range of contraceptive services, including coil fittings, implants and an in-house vasectomy service was offered to parents.

We saw joint working arrangements were in place with midwives and health visitors. This included multi-disciplinary meetings to discuss at risk families and safeguarding concerns. However, the

systems in place for recording safeguarding concerns required strengthening to evidence appropriate follow up actions had been undertaken to ensure children were safe. Immunisation rates were relatively high for all standard childhood immunisations.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included: extended hours between 8am and 11.15am on a Saturday at the main Barlborough practice; telephone consultations and access to a triage system which could be used for accessing advice. Patients had access to useful information and services relating to minor illnesses.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Data reviewed showed the practice achieved high uptakes for its screening programmes including: cancer, cervical smears and blood pressures for patients aged 45 and above. The practice's performance for the cervical screening programme was 85.7%, which was above the national average of 70% and CCG average of 79%.

A vasectomy service was offered within the practice and this was one of three services within the clinical commissioning group area. Patient feedback about this service was strongly positive. The practice facilitated regular sessions by the citizens advice bureau within the practice. Patients could access this service for advice on work, housing and benefits for example.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with a learning disability.

The practice had 24 patients aged 14 and over, recorded on the learning disability register. Fifty eight percent (58%) of eligible patients had received a health check this year and of those 100% were provided with a health action plan. The practice allocated one hour health check appointment slots for patients with learning disabilities and about a third of these were undertaken as home visits. This was very well received by patients and their carers.

Summary of findings

The practice's learning disability enhanced service had been reviewed on 27 May 2015. The findings showed the lead nurse was providing excellent service to patients and provided thorough and comprehensive health checks to the patients. Easy read resources were used to communicate with patients and the practice had good links with the learning disabilities specialist team.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice's community matron and care coordinators played a key role in the case management of vulnerable patients; in liaison with other health and social care professionals. Patients discharged from hospital received follow-up calls to check they had all their medicines, care plans and support in place. Patient feedback confirmed this was a valued service.

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).

The practice had 24 patients recorded on the mental health register and all of them had received an annual health check in the last 12 months. Data reviewed showed 94.4% had a comprehensive care plan in place to ensure they received safe care and treatment. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Psychological services such as counselling and cognitive behaviour therapy were also offered within the practice. A robust system was in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

The practice had 67 patients recorded on the dementia register for 2014/15 and 92.5% had received a review in previous 12 months. The practice was proactive in facilitating timely diagnosis and support for people with dementia. Data showed the practice had the highest dementia diagnosis rate in the local Clinical commissioning group area and was eleventh in the entire NHS England local area team.

The practice carried out advance care planning for patients with dementia. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health and dementia. This included hosting the weekly community support team meeting. Suitable systems were in place to ensure effective communication with the community mental health team, hospital psychiatric services and nursing homes.

Summary of findings

What people who use the service say

We spoke with seven patients during our inspection and received written comments from a member of the Patient Participation Group (PPG). The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Patients expressed a high level of satisfaction about the way the services were provided. They told us staff were compassionate and responsive to their care needs. They confirmed having regular reviews of their health needs and medicines. They felt involved in decisions about their treatment and were promptly referred to other services for support.

A few patients reported difficulty in telephone access in the mornings but they confirmed that appointments were relatively easy to access. The practice was aware of the telephone access issues and this was being reviewed. A contributing factor had been a 10% increase in the practice population as a result of new patients joining from another local practice.

We received 69 completed comment cards. Patient feedback was overwhelmingly positive with most patients confirming they had consistently received an excellent service. Common themes included:

- Patients said that staff treated them with dignity and respect
- Patients said that staff were welcoming, friendly and helpful
- Patients felt cared for, listened to, involved in decisions about their care and were provided with adequate information to make an informed decision
- Good telephone and appointment access, and
- Referrals for further investigation had been promptly made and followed up.

Four comment cards contained negative comment to waiting times and access to appointments but were still generally positive. There was one negative comment card related to the attitude of a clinician.

Two care homes we spoke with praised the support received from the practice, and the care and service patients received. They said that patients were promptly seen and their needs were regularly reviewed.

The practice provided results of its friends and family test. The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The majority of the comments received were extremely positive and patients stated they would recommend the GP practice to friends and family. Patients found the staff caring and found it easy to access the care and treatment they needed. A small number of patients indicated that it was sometimes difficult to get an appointment at a convenient time.

The practice's February 2015 results showed over 150 patients participated in the practice's annual survey and 99% rated their overall experience as excellent or good. Detailed results are available on the practice website for review.

We looked at the national GP patient survey results published in January 2015; of which 117 patients completed. The findings were compared to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services.

Areas where the practice scored highest included: waiting less than 15 minutes after their appointment time to be seen; easy to get through by phone and the overall experience of making an appointment. Areas the practice could improve on included: nurses involving patients in decisions about their care and GPs treating patients with care and concern.

Summary of findings

Areas for improvement

Action the service MUST take to improve

Ensure a risk assessment is in place and / or a Disclosure and Barring Service (DBS) check has been received before any member of staff can undertake chaperone duties.

Action the service SHOULD take to improve

- Ensure systems in place for recording significant events and safeguarding discussions in respect of children are strengthened to give a clear and accurate picture of safety and information discussed.
- Ensure completion of e-learning by staff is actively monitored to assure the provider that staff have completed relevant training in a timely way.

Outstanding practice

- Patient feedback was overwhelmingly positive about the way staff treat people and most patients confirmed they had consistently received an excellent and caring service. This was corroborated by positive patient survey results from different sources and external professionals we spoke with.

Dr A Palmer & Dr J Gardner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead Inspector. The team included a GP, a practice manager, and two inspectors.

Background to Dr A Palmer & Dr J Gardner

Dr A Palmer & Dr J Gardner also known as Barlborough Medical Practice is situated in the heart of village of Barlborough. It was formed in 1993 and currently operates from two sites: a main surgery at Barlborough and a branch at Renishaw.

The practice provides a service to patients living in Barlborough, Renishaw, Clowne, Eckington, Killamarsh, Spinkhill, Mastin Moor, Marsh Lane, Harthill, Whitwell, Elmton, Mosborough, Halfway, Norbriggs and Stanfree.

The practice has a patient list of about 6 420 and expects to increase steadily. The practice offers a dispensing service to about 500 patients. A dispensing practice is able to provide medications directly to any of patient who lives more than a mile from a chemist.

For this inspection we visited the main location registered with the CQC. The addresses for the main location and branch surgery are:

- Barlborough Medical Practice, The Old Malthouse, 7 Worksop Road, Barlborough Chesterfield, Derbyshire and S43 4TY and
- Emmett Carr Surgery, Abbey Place, Renishaw, Sheffield, S21 3TY.

The Barlborough practice is open between 8am and 6.30pm Monday, Wednesday and Friday; 8am to 4pm on Tuesday and Thursday; and 8am to 11.15am on a Saturday.

The Renishaw surgery is open from 8am to 1pm; and 2pm to 6.30pm on a Monday, Tuesday and Thursday; and from 8am to 1pm on Wednesday and Friday.

The practice is a partnership of two GPs; and they are supported by one part time salaried GP. Two of the GPs are female and the senior partner is male. The nursing team comprises two nurse practitioners, a practice nurse and a community matron. The community matron is assisted by a part time health care assistant and two care co-ordinators in co-ordinating care for frail and elderly patients.

The non-clinical staff includes a practice manager, seven staff undertaking dual roles in respect of secretarial and administrative tasks as well as dispensing activities, and a cleaner / caretaker.

The practice holds a Primary Medical Services (PMS) contract with the NHS to deliver essential primary care services. The practice offers four directed enhanced services in respect of: avoiding unplanned admissions, extended hours access, facilitating timely diagnosis and support for people with dementia and learning disabilities health check service.

Patients also have access to a range of services including child health monitoring, contraceptive services including vasectomy, minor surgery, anticoagulation clinics, chronic disease management and health screening programmes.

The practice has opted out of providing the out-of-hours services to their own patients. Derbyshire Health United currently provides the out of hours service.

Detailed findings

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 as part of our regulatory functions and in response to information we received.

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included NHS England, Health watch and the North Derbyshire Clinical Commissioning Group.

We carried out an announced visit on 09 June 2015. During our visit we spoke with a range of staff (GPs, nurse practitioner, practice nurses, community matron, care coordinator, health care assistant, practice manager, reception and administrative staff). We also spoke with four health and social care professionals who worked closely with the practice.

We spoke with seven patients who used the service and observed how people were being cared for. We reviewed 69 comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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.

National patient safety alerts were disseminated by the practice manager to relevant 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 told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Records confirmed national patient safety alerts were reviewed and any resulting actions were followed up. Additionally, staff signed to confirm having read the alerts.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses using the practice form available on the intranet. For example, the practice had recorded a recent incident whereby someone had attempted to obtain confidential information about a patient over the telephone. Staff were reminded of patient confidentiality and staff we spoke with demonstrated awareness of this.

The practice had shared with the Care Quality Commission (CQC) and the clinical commissioning group (CCG) two incidents of unexpected death. A system was in place to undertake after death analysis including for patients receiving palliative care.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 20 significant events that had occurred during the last two years and saw this system was implemented in practice. Examples of identified significant events included an incident involving cervical cytology, wrong medication dispensed by pharmacy and specific actions not being communicated to patients.

A dedicated meeting was held on 13 May 2015 to review significant events received within the year. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Some staff told us significant events were discussed when they occurred, however we found limited supporting documentation to confirm that significant events were regularly discussed throughout the year before the annual review.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been identified.

Staff told us that learning was shared with them but this was not recorded formally in meeting minutes. For example, staff were reminded of the importance of checking patient identifiable information following an incident of two patients' information being mixed up. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

They were also aware of their responsibilities and knew how to share information, record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The two GP partners were the leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate

they had the competence and training to enable them to fulfil these roles. All the staff we spoke with were aware of who the leads were and who to speak with at the practice if they had a safeguarding concern.

The lead safeguarding GP was aware of the practice's vulnerable children and adults, and records demonstrated meetings were held with the midwife and health visitor. The level and quality of recording in the meeting minutes we reviewed did not evidence a robust picture of safeguarding concerns relating to children had being adequately reviewed, followed up and monitored.

However, the midwife we spoke with assured us that the meeting minutes were signposting documents and detailed information was contained in the patient's individual notes. The midwife also said any safeguarding concerns shared with the GP were appropriately followed up there were no concerns about safety from their perspective. Following our inspection we also received written assurances to confirm improvements had been made to the recording form and systems to demonstrate the actions taken to keep people safe.

We found that on most occasions, GPs were using the required codes on their electronic case management system to ensure risks to children and young people and those on child protection plans were clearly flagged and reviewed. This ensured that staff were aware of any safeguarding concerns when patients attended appointments.

The practice held weekly community support team meetings which were attended by practice staff, district nurses, social care staff, community psychiatric nurses and allied agencies. They discussed vulnerable patients, safeguarding concerns and were proactive in monitoring if children or vulnerable adults attended accident and emergency, failed to attend their appointments with the GP or nurse or for childhood immunisations. We saw minutes of meetings to confirm these discussions.

There was a chaperone policy in place, which was visible in consulting rooms but was not displayed in the waiting area. Following our inspection, we received written assurance that the chaperone policy was now displayed in the waiting area and we saw that a copy of the policy was also available on the practice website. 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 staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and most of them understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

All clinical staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found no DBS checks or risk assessments had been completed for non-clinical staff expected to undertake chaperone duties. This was discussed with the leadership as it is a requirement to safeguard patients and staff. Following our inspection, the practice sent us a risk assessment confirming that all non-clinical staff would not be undertaking chaperone duties until their checks had been completed; and the chaperone policy was amended to reflect this.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperatures. Action had been taken when the practice had experienced a recent power failure to ensure the safety of medicines.

Processes were in place to check medicines were within their expiry date and suitable for use. These were checked regularly; but not documented. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Requires improvement

Are services safe?

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as lithium, methotrexate and other disease modifying drugs, which included regular monitoring of blood tests in accordance with national guidance. Appropriate action was taken based on the results. Records reviewed showed patients on repeat medication had a minimum of one annual review.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. Records reviewed showed clinical audits looked at the care and treatment for children with high dose steroid use and frequent inhaler ordering for example.

Three monthly checks were also undertaken to ensure all patients taking disease-modifying anti-rheumatic drugs (DMARDs) under shared care guidelines were having required blood monitoring. DMARDs are medicines used to slow down the progression of disease. Robust recall systems were in place to ensure patients attended their medicine reviews.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for these drugs.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in 2014. The nurses administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber.

They had received appropriate training and were assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

The practice had established a service for patients to pick up their dispensed prescriptions at the Barlborough practice. There were systems in place to monitor how these were collected to ensure patients collecting medicines were given all the relevant information they required.

The practice had appropriate written standard operating procedures in place for the production of prescriptions and dispensing of medicines which reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

The practice's 2015 survey results showed most patients were happy with the arrangements in place for ordering their medicines. For example:

- 99% of patients found it easy to order their repeat prescriptions (88% very easy and 11% moderately easy)
- 46% of patients ordered their by telephone, 20% via the pharmacy, 14% in person, 18% by prescription counterfoil, 2% on-online.

We saw a positive culture in the practice for reporting and learning from medicine incidents and errors. Incidents were logged and then reviewed promptly to ensure appropriate actions were taken to minimise similar errors occurring again.

Cleanliness and infection control

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

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example,

personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had a GP lead for infection control and they had relevant training to enable them to provide advice on the practice infection control policy and to carry out staff training. All staff received induction training about infection control specific to their role and had received an update in January 2014. We saw evidence that the practice had carried out audits for each of the last two years and that any improvements identified for action were completed.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice had undertaken a risk assessment for legionella and identified this as a low risk. Checks in line with this policy and assessment were undertaken to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of 05 November 2012 and was due to be reviewed 05 November 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Four staff files we looked at contained evidence that appropriate recruitment checks had been undertaken prior to staff employment.

For example, we saw proof of identification, qualifications, registration with the appropriate professional bodies and the appropriate checks through the Disclosure and Barring Service . These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

We also saw that relevant checks had been made with the General Medical Council, clinical commissioning group and NHS England to ensure a locum GP was registered and allowed to work. We however, noted that formal references had not been obtained for two of the staff records we looked at.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough people were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave on an overtime basis.

The practice had a staffing needs assessment in place. They were able to evidence occasions when they had increased their number of clinical sessions and available appointments to reflect their increasing list size and changing patient needs. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

However some staff acknowledged pressure on staffing levels due to an increase in their patient list size by 10% within the last 12 months. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements; and adjustments such as employing locum GPs or increasing staff hours were considered to meet patients' needs.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors

to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy in place and this was accessible for staff to see. We saw risk assessments related to lone working, slips, trips and falls and the environment.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of this and the mitigating actions that had been put in place. Some staff told us risks were discussed at team meetings however there were limited records to confirm this; although the provider advised this would be addressed.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Staff gave examples that demonstrated that appropriate action had been taken for patients displaying the following symptoms: chest pains, worsening foot ulcer and asthma attacks. A flagging system on the patient record was in use by the receptionists to highlight any concerns and for review by the duty clinician.

There were emergency processes in place for patients with long-term conditions, those experiencing poor mental health, acutely ill children and young people. For example, staff gave us examples of referrals made to hospitals for patients whose health deteriorated suddenly; and prescribing of rescue packs for patients with chronic obstructive pulmonary disease (COPD) - the name for a collection of lung diseases.

The practice also liaised with the community mental health team to ensure patients experiencing a mental health crisis were supported to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia 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.

A crisis management 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 the Renishaw branch surgery, computer system, power failure and incapacity of staff. Mitigating actions were recorded to reduce and manage the risk.

The plan also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in June 2015.

The practice had a fire risk assessment in place and this included actions required to maintain fire safety. A schedule was in place to ensure the regular maintenance of the fire alarm system, intruder alarm, fire extinguishers and emergency lighting. Records reviewed showed all practice staff were up to date with fire training.

We found limited records to demonstrate that regular fire drills were being undertaken. Following our inspection, we received written assurances to confirm that a fire drill had been undertaken the day after our inspection on 10 June 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Guidance from local commissioners was readily accessible to all GPs and nurses.

We discussed with the practice manager, GP and nurses how NICE guidance was received into the practice. They told us this was accessible from the website and the clinical system, and each clinician had an individual responsibility to access the information.

Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. They told us changes to NICE guidelines were discussed in clinical meetings and implications for the practice's performance and patients were identified and required actions agreed.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. Feedback from patients confirmed they were having regular health checks and were being referred to other services or hospital when required.

The practice supported a 'diabetes care model' which concentrated on the delivery of care and treatment in a primary care or community setting so as to avoid too many hospital follow ups. This included the nurse practitioner being able to assess patients with a diagnosis of diabetes and initiate insulin treatment within the practice.

A similar approach to patients diagnosed with chronic obstructive pulmonary disease (COPD is the name for a collection of lung diseases) was adopted in collaboration with specialist respiratory nurses. The practice's prevalence rate for COPD was below the national and local clinical commissioning groups (CCG) averages and data showed 91.67% of patients were receiving intervention. Records reviewed also showed that COPD was a priority area for the local CCG in 2014. A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services.

The GPs told us they led in specialist clinical areas such as diabetes, dermatology and vasectomy and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used information relating to out of hours activity, accident and emergency attendance (A&E), admission and discharges, to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records. We saw that the care coordinators and community matron followed up on patients after they were discharged from hospital to ensure all their care needs continued to be assessed and reviewed.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, coordinating the care of elderly and frail patients, and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us seven clinical audits that had been undertaken recently. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit and improved outcomes for patients. For example, an audit which analysed cervical cytology samples taken between January 2012 and December 2013 showed 35 out of 709 tests had an inadequate sample result.

The initial audit identified steps to reduce inadequacy rates which was shared with the clinical staff. A second audit undertaken in March 2014 showed a significant reduction

Good

Are services effective?

(for example, treatment is effective)

in the number of inadequate samples from 2.7% to 0.14%. Another audit relating to vasectomy procedures showed no patients presented with skin or wound infections following the procedure.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The 2014/15 QOF data showed an achievement of 99.1% which was an improvement from the previous year by 7.8%.

This practice was an outlier for one blood pressure target for patients with a diagnosis of diabetes. The practice had undertaken an audit in response to this information and staff were due to attend a relevant course to update their knowledge.

The practice's prescribing rates were comparable to national and local figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence 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 practice had a palliative care register and facilitated multidisciplinary meetings to discuss the care and support needs of patients and their families. This included Macmillan nurses from the local hospice. The practiced aimed to work towards the gold standards framework and assessed patients using a traffic light coding system based on an expectation of prognosis.

An after death analysis was undertaken to review if a patient had been able to end their life in their preferred place, whether appropriate care plans were in place and any learning points for the team.

Structured annual reviews were undertaken for people with long term conditions and these were linked to the patient's month of birth. For example, the QOF data as at 09 June 2015 showed that :

- 82.9% of patients on the asthma register had received a review in the previous 12 months;
- 89.2% of patients on the COPD register had received a review in the previous 12 months and
- 81% patients on the rheumatoid arthritis register had received a review in the previous 12 months.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable or better to other services in the area. For example in respect of emergency admissions and A&E attendances.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending courses such as annual basic life support. However, we found the system to monitor completion of allocated e-learning training needed to be strengthened to ensure staff had completed this in a timely manner.

We noted a good skill mix among the doctors who lead on different clinical areas such as cancer, controlled drugs and anti-coagulation. All GPs were up to date with their yearly continuing professional development requirements. They 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.

Most staff had received annual appraisals that identified learning needs from which action plans were documented; and a future date for appraisal had been scheduled for other staff. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses and staff were paid for undertaking e-learning training at home.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. Those with extended roles for example

seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice had a data recording policy outlining the responsibilities of all relevant staff in reading and acting on any issues arising from these communications. Test results and hospital letters were seen and dealt with by the duty doctor and then passed to a second doctor to be filed or actioned.

The GP made administrative staff aware of any action which needed to be taken such as calling a patient in for a follow up appointment. The practice felt that having two GPs see correspondence added a safeguard to ensure all follow-up action was addressed.

The practice held weekly multi-disciplinary team meetings, known as community support team meetings to discuss patients with complex needs. These meetings considered the clinicians' caseloads, out of hours activity, A&E attendances, hospital admissions and discharges. Patients discussed included those with multiple long term conditions, experiencing poor mental health, receiving end of life care and / or children on the at risk register.

The meetings were attended by district nurses, social care, community psychiatric nurse and decisions about care planning were documented. Staff felt this system worked well, provided a valuable point of contact for sharing information and was beneficial in supporting integrated care.

Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. We saw comprehensive minutes of these meetings.

The practice was commissioned for the unplanned admissions enhanced service and had identified care plans in place for 2.8% patients at most risk of hospital admissions. This was above the recommended 2%.

Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. A process was in place to follow up patients discharged from hospital. We saw that the policy for actioning hospital communications was working well in this respect.

We saw that care plans had been developed to meet their individual care needs and all these patients had a named GP to ensure continuity of care. Supported care was also targeted for patients with long term conditions including telephone follow-ups in between attending surgery and referrals to occupational health for equipment.

Patient feedback, discussions with staff and data we reviewed confirmed positive outcomes were achieved as a result of these meetings. For example, the practice's A&E attendance rate was lower compared to the national and CCG average between April 2012 and March 2015. The practice attributed this low rate to their commitment in delivering good quality care in liaison with other providers.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw a system was in place for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services on a weekly basis.

The practice provided a printed copy of a summary record for patients to take with them to Accident and Emergency. The practice had signed up to the electronic Summary Care Record and this was fully operational. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Electronic systems were also in place for making referrals. Patients had access to the choose and book system, which enabled them to choose which hospital they wished to be

Good

Are services effective?

(for example, treatment is effective)

seen in, and to book their own outpatient appointments. Data reviewed showed 771 GP referrals had been made between April and October 2014 of which 73.41% were made via choose and Book.

Consent to care and treatment

We found that most staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 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. Some non-clinical staff had some awareness of the principles of this legislation but had not received specific training.

The practice had a consent policy which highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure.

In addition, the practice obtained written consent for minor procedures and all staff were clear about when to obtain written consent. We were shown evidence of consent obtained for vasectomy procedures following patients having attended counselling consultations.

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) and had a section stating the patient's preferences for treatment and decisions. For example, 58% of patients on the learning disability register had received a health action plan with consent decisions recorded.

Most staff were able to give examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

The practice offered a health check with the practice nurse or nurse practitioner to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in reviewing their mental and physical wellbeing. For example, the practice had identified the smoking status of 90.5% of patients over the age of 16 within the last 12 months and actively offered smoking cessation clinics to these patients.

There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was about 45.5%. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. The practice data showed 56% of patients in this age group took up the offer of the health check this year. The practice's performance for the cervical screening programme was 85.7%, which was above the national average of 70% and CCG average of 79%.

There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The 2014 Public Health data reflected the practice's cancer screening was in line with or above CCG and national average and 1.6% of the practice population were on the practice's cancer register. For example:

- 78.2% of females between 50 and 70 years had been screened for breast cancer in the last three years. This was above the 77% CCG average and 72.2% national average.
- 79.4% of these females had been screened for breast cancer within 6 months of invitation compared to a 79.6 % CCG average and 73.2% national average.

Good

Are services effective?

(for example, treatment is effective)

- 67.7% of patients between 60 and 69 years had been screened for bowel cancer in the last 30 months (2.5 year coverage); compared to a 63.1% CCG average and 58.3% national average
- 67.7% of these patients had been screened for bowel cancer within 6 months of invitation compared to 60.4 % CCG average and 55.4 % national average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Childhood immunisation rates for the vaccinations given to under twos ranged from 93.9% to 100% and five year olds from 95.7% to 100%. These were comparable to the local CCG average.

The practice actively promoted maintaining healthy lifestyles by signposting and giving out information packs to patients in respect of: weight management for adults, "healthy kids / healthy lives", "managing minor illness: self-help" and sleep management for example. Information to promote screening programs was also displayed on noticeboards and themes included: "Movember - men's health concerns," and "Smears: pointing out the benefits of the cervical screening programme."

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback received from patients was strongly positive and most of them felt they were truly respected and valued as individuals. Comment cards received and recent data available for the practice on patient satisfaction also confirmed these views. This included information from: the practice's 2014 and 2015 survey results; the national patient survey published in January 2015 and comments from the family and friends test.

The 2014 patient participation group (PPG) survey results showed 90% of the 20 respondents were satisfied with the level of clinical care they had received. This was aligned with the practice's 2015 survey results which showed 99% of the 150 practice respondents were very happy / happy with the care received from both the GPs and nurses.

A PPG is a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

The national patient survey included responses collected during January to March 2014 and July to September 2014. There were 258 survey forms sent out of which 117 responses were received. This represented a 45% completion rate. The majority of the 117 respondents rated the practice as good or very good for most of its satisfaction scores on consultations with nurses and doctors. For example:

- 96% had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 98% and national average of 97%
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 94% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 94% and national average of 91%.
- 87% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 94% and national average of 92%

The areas the practice did not perform as well in were;

- 88% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 84% said the GP gave them enough time compared to the CCG average of 91% and national average of 87%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 69 completed cards and all but one were very positive about the service experienced. Patients felt the practice offered an excellent service and staff were very caring, efficient and listened to their individual needs.

Specific examples given included: reception staff being polite and helpful, nurses being sensitive and gentle when taking bloods and GPs being empathic when supporting patients experiencing depression and anxiety. Some cards mentioned specific members of staff whom patients felt were very caring and provided very good care. One comment was less positive and three were mixed but there were no common themes to these.

We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their privacy and dignity was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

The practice had a notice displayed by the reception desk which directed patients to be aware of confidentiality of others and to stand back from the desk. This prevented

patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

The national survey results showed 93% of respondents found the receptionists at the practice helpful compared to the local CCG average of 89% and 87%. This was aligned to the practice's 2015 survey results which showed 95% of the receptionists were very helpful and 5% were reasonably helpful.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us he would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour, this was also referenced in the practice leaflet. The staff had access to panic buttons that were linked to emergency services.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas although some values were comparable to the CCG average. For example:

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 86%
- 85% said the last GP they saw was good at involving them in decisions about their care which was in line with the CCG average of 86% and national average of 81%
- 89% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%
- 76% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%

Patients we spoke with told us their 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 very positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language, although this service was not regularly used as most patients could communicate in English.

We reviewed four care plans for patients with dementia, at risk of hospital admission and with long term health conditions. There was evidence of patient involvement in agreeing these and relevant information to ensure they received safe care and treatment. For example, their medical health needs and medicines, arrangements in place to respond to the patient's changing care needs and their preferred place of care.

The annual health check evaluation report for the learning disabilities enhanced services stated the practice nurse knew each patient personally, considered their needs as individuals and completed thorough and comprehensive health checks. This report was written by one of the lead learning disability strategic health facilitators within Derbyshire.

The practice's 2014/15 Quality and Outcomes Framework (QOF) data showed high percentage points had been achieved in respect of comprehensive care plans completed for people with mental health and a range of long term conditions.

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 and for the implementation of preventative measures.

For example:

- 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate.

Good

Are services caring?

Feedback from patients showed children and young people were treated in an age-appropriate way, recognised as individuals and had their preferences considered.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed most patients were positive about the emotional support provided by the practice although this was below the CCG and national averages. For example:

- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.
- 82% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.

The patients we spoke with, the comment cards and the friends and family test information, showed that patients were supported emotionally and had access to counselling services. Patients told us staff responded compassionately when they needed help and provided support when required. Patients also had access to onsite counselling services. Notices in the patient waiting area and patient website also told patients how to access a number of support groups and organisations.

The practice had identified 221 carers and the computer system alerted GPs if a patient was a carer. Where appropriate, referrals had been made to Derbyshire Carers Association and social services to ensure carers received support. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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

The practice maintained a register of 430 patients who were diagnosed with depression of which 58 patients aged 18 and over had received a new diagnosis in the preceding year.

Staff we spoke with recognised isolation as a risk factor for some of the practice population particularly older people, people with long terms conditions or experiencing poor mental health. Meeting minutes reviewed showed good collaborative working with other health and social care professionals to address this need. One care coordinator gave an example of how practice staff had referred five ladies to a local luncheon club and created a peer support network for them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The NHS England Area Team and North Derbyshire Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and improvements that needed to be prioritised. A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services.

For example, the practice was engaged in service improvement work with other local practices to initiate medication for patients with a diagnosis of dementia within practices. This was in response to concerns about the length of time before patients were diagnosed when referred to the memory clinic. The practice was also signed up to the enhanced service for facilitating timely diagnosis and support for people with dementia.

Records reviewed showed the practice had high dementia diagnosis rates and was the second highest within the CCG area and twelfth in the NHS England local area. "Memory Concerns: increasing awareness of Dementia and Alzheimer's" was a key theme which had been promoted on the practice's patient noticeboard.

Meeting minutes reviewed showed good examples of multi-disciplinary working in respect of assessing, planning, delivery and review of patients' care. The practice hosted the weekly community support team meetings which aimed to deliver coordinated care that was "wrapped around" the patient.

These meetings were attended by professionals from health, social care, community mental health team and local hospice. Any concerns noted were assigned to a named clinician or care coordinator to follow-up on and feedback at the next meeting. Records reviewed showed patients discharged from hospital were contacted by the care coordinators to ensure their care needs were being met in the community.

The practice had also received funding from the CCG to employ a community matron who took a lead in co-ordinating the care for frail and elderly patients; with the support of two practice employed care co-ordinators. At the time of our inspection the community matron had a caseload of 43 patients and provided home visits and telephone advice to these patients. Patient feedback was complimentary of the service received.

The needs of the practice population were understood and systems were in place to address identified needs. For example a range of clinics for the management of long term conditions such as asthma, chronic obstructive airways disease (COPD) and diabetes were offered; as well as specialist clinics for anti-coagulation monitoring, smoking cessation and vasectomy.

The vasectomy clinic was accessed by patients from other neighbouring practices as it one of three in the CCG area. To increase the flexibility of appointments available to patients, the practice did not have set times for specific clinics. The clinics were designed around the needs of the patients.

Feedback from two care home managers we spoke with showed the practice was responsive to patients' needs. For example, GPs supported their patients to receive care at the care home reducing the need for a hospital admission and ensured they were seen when unwell. Fortnightly visits were undertaken at the care home or patients were seen when needed.

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). For example, a themed noticeboard had been introduced in the waiting area to promote health screening and empower patients to look after their health. This included information on shingles and "breast awareness: to promote the benefits of self-checking prior to seeking medical advice.

The practice had also implemented the PPG's suggestion to send letters or texts to patients who had failed to attend appointments. The practice had a 3% do not attend rate and this was monitored on a monthly basis. On the day of the inspection we saw a board which raised awareness of the importance of attending or cancelling patients to ensure these were available for patients who needed them.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

experiencing poor mental health and those with learning disabilities. The practice nurses also carried out home visits for around a third of their patients on the learning disability register to increase uptake of annual health checks.

The practice had received an annual health check quality monitoring visit for its learning disability enhanced service in May 2015. The report summary stated that the lead nurse ensured reasonable adjustments were put into place when completing the health checks. This included easy read information, pictorial letters and a telephone call to remind patients and their carers of their health appointments.

Reasonable adjustments are a legal requirement under the Equality Act 2010, and practices are required to make changes to service provisions so that patients with learning disabilities can use them like anyone else and achieve the same outcomes.

The majority of the practice population were English speaking patient and the Public Health Practice Profile showed the practice population was 98.5% white British. Access to online and telephone translation services was available if needed. Sign language services were also available for patients who had a hearing impairment.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities.

There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were homeless but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were two female GPs and a male GP in the practice; therefore patients could choose to see a male or female doctor. The practice provided equality and diversity training through e-learning. However, most staff had not completed this training in the last 12 months. The practice manager assured us this would be monitored after our inspection to ensure all allocated e-learning training was completed by September 2015.

Access to the service

Comprehensive information was available to patients about appointments on the practice website and leaflet. This included how to arrange urgent appointments, home visits and how to book appointments through the website. Appointments could be booked by telephone, in person or online.

Same day appointments were available for emergencies and for patients who genuinely felt they needed to be seen. When these appointments had been taken up, a telephone triage system was operated by the GP and or nurse practitioner and telephone consultations were also available.

The main surgery at Barlborough was open from:

- 8am to 6:30pm Monday, Wednesday and Friday;
- 8am to 4pm Tuesday and Thursday; and
- 8am to 11.15am on Saturday.

The surgery at Reinshaw was open from:

- 8am to 1pm and 2pm to 6.30pm Monday, Tuesday and Thursday; and
- 8am to 1pm on Wednesday and Friday.

There were arrangements to ensure that patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Derbyshire Health United provided out of hours cover when the surgery is closed.

Most patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice.

Comments received from patients showed patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

A few patients reported difficulty in telephone access in the mornings specifically. Practice staff told us that one of the reasons for this was a recent 10% increase in the practice population.

The practice audited its appointment system to ensure it had adequate capacity to meet people needs. On average, 3000 patients were seen each month and about 1000 queries were also received per month. These queries included advice with minor illnesses and medicines.

Additional GP surgeries were offered on a Monday morning in response to winter pressures and were complemented by additional flu clinics led by the practice nurse and health care assistant.

The results of the national GP patient survey published in January 2015 showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 90% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%
- 89% described their experience of making an appointment as good compared to the CCG average of 76% and national average of 73%
- 86% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%
- 76% were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 75%

Additionally, the practice's 2015 patient survey results showed most patients had a good experience of accessing the practice. For example:

- 85% said it was very easy / easy to get through to the surgery on the phone
- 95% were able to make an appointment or speak to someone when they last needed to
- 92% were able to book an appointment time convenient for them and
- 97% rated their overall experience of booking appointments as very good / good
- 89% said they were happy with the opening times of the surgery

Longer appointments were available for older patients, those experiencing poor mental health and patients that were housebound. This also included appointments with a named GP or nurse. Care home visits were made to a local care home each fortnight, by a named GP and to those patients who needed one.

Appointments were available outside of school hours for children and young people and extended houses were available on a Saturday morning for working age people. Flexible services and appointments, including for example, avoiding booking appointments at busy times for people who may find this stressful were also offered.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. For example, a complaints leaflet and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found these were dealt with appropriately and in a timely way. We saw evidence that the practice accepted complaints verbally and in writing.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement to offer patients a professional, efficient and caring primary care service. They told us they promoted a culture of being there 'for the right reasons' and to do the very best they could for their patients.

We spoke with 11 members of staff and they all knew the vision and values, and understood what their responsibilities were in relation to these. Some of the staff had been involved in developing these values and agreed they were still relevant.

The practice had noted a 10% increase in its practice population as a result of a sudden increase in the number of new patients registering from a local practice. This had an impact on service provision. For example, staff told us some of the new patients' clinical care needs required regular review resulting in an increased need for effective chronic disease management. The increase in patient list had also impacted on telephone access, appointments and staffing.

However, the practice team had managed to cope within the available resources and succession planning was taking place. This practice team felt this was a significant achievement in that it demonstrated strong team working and resilience to change. A review of written comments by six patients from this former practice showed patients fully appreciated the high quality of care they now received at Barlborough practice.

Governance arrangements

The practice had a strong leadership and a commitment to ensuring quality services were delivered. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for infection control, safeguarding, prescribing, information and clinical governance. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP partners and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework (QOF) to measure its performance.

QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The 2014/15 data showed an achievement of 99.1%. We saw that QOF data was used to drive improvement and to maintain or improve clinical outcomes for patients.

Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 20 of these policies and procedures and most of them had been reviewed annually and were up to date.

The practice manager was responsible for human resource policies and procedures; and at the time of our inspection they were in the process of updating all policies and transferring them to a new electronic system. Staff we spoke with knew where to find these policies if required. In some cases, staff had signed to confirm they had read the policies and procedures. We were shown the electronic staff handbook that was available to all staff, which included sections on equal opportunities, harassment, disciplinary and grievance procedures.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example use of display screen equipment such as computers. The practice monitored risks on a regular basis to identify any areas that needed addressing.

The practice held staff meetings at least every two months on average where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

Are services well-led?

Good

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

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. Staff told us they felt well supported by the practice management and often had team lunches.

Most staff felt involved in discussions about how to run the practice and how to develop the practice. They told us the management encouraged them to identify opportunities to improve the service delivered by the practice.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected and valued particularly by the partners in the practice.

The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice. None of the staff we spoke with had cause to use it.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the virtual patient participation group (PPG), surveys and complaints received. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

The practice had an active PPG comprising of 45 members of which two members attended the bi-monthly locality PPG Network group. The PPG carried out annual surveys and mainly communicated with the leadership via email; with the chair having face to face meetings with the practice manager. This was confirmed by written feedback received from one member of the PPG and information available on the practice's website.

The practice manager showed us the analysis of the 2014 and 2015 patient surveys, which were considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. The PPG had shared its medication waste campaign with other practices and this had been adopted by other local practices and Hardwick CCG. We saw posters regarding this in the waiting area.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had fully been supported to attend the nurse practitioner and prescribing training as part of their professional development. Staff told us they felt involved and engaged in the practice to improve outcomes for patients.

The practice had a long established practice team with good local knowledge of patients. Staff felt this was hugely beneficial to continuity of care for patients and this was an area patients commented as being of high importance to them. Clinical staff praised their administrative colleagues for knowing patients really well and flagging up concerns relating to their health and / or safeguarding.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that staff employed for over a year had either received an appraisal which included a personal development plan; or had an appraisal planned for a future date.

Staff told us that the practice was very supportive of training and they had protected learning time where guest speakers and trainers attended. Nurses we spoke with told us of the peer discussions they had facilitated in response to requirements for revalidation with the Nursing Midwifery Council.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We found recording systems needed to be strengthened to ensure a clear picture of safety issues discussed, actions taken and lessons learnt were documented.

The practice leadership attended the quarterly CCG clinical governance meetings and the locality meetings with four other practices. The benefits of these meetings included sharing best practice and involvement in the planning and delivery of services to improve patient outcomes.

For example, the practice manager was actively involved in work groups which had secured partial funding from the CCG for online training and a software package to aid the management of data within all local practices.

Are services well-led?

Good

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

The practice manager told us the use of the software ensured staff had up-to-date information available from one source which informed their planning and delivery of care. The CCG confirmed the practice was actively involved in pilot projects relating to IT and staff would test these before they were rolled out to other practices.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found non-clinical staff undertaking chaperoning duties had no risk assessments in place and Disclosure and Barring Service (DBS) checks had not been received at the time of our inspection. This did not ensure appropriate safeguards were in place to protect patients. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.