Dr M. R Spencer & Partners

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

We inspected Dr M. R. Spencer & Partners practice (Welbeck Health Centre), Bolsover on 07 October 2014 as part of our new comprehensive inspection programme. For this inspection, we did not visit the branch surgery in Glapwell as the provider had previously been inspected in December 2013.

Our key findings were as follows:

- Patients using the service were treated with dignity and respect, and they felt involved in decisions about their care and treatment.
- Patient needs were assessed and care was planned and delivered to ensure their welfare and safety.
- The practice was responsive in meeting the different population groups' needs including improvements to phone and appointment access.
- The provider had effective systems in place for the safe management of medicines, equipment, infection control and dealing with emergencies.
- The practice worked with other providers to ensure patients were supported to maintain good health outcomes.
- The practice was well led, and learning and development of staff was promoted

We saw several areas of outstanding practice including:

- A strong learning culture and commitment to continued quality improvement, including working with the productive general practice programme. This culture was embodied by all of the staff.
- A drive by the whole practice team to constantly innovate and improve the services it provides for its patients'. This included initiatives to promote patients physical and mental health wellbeing. For example, promoting adult literacy for patients with mental health needs and Bolsover Wellness (working with health trainers, providing onsite gym facilities, chair-based exercise classes and facilitating a falls prevention group).
- The practice promoted work with young people and schools as part of "You're welcome initiative". This included engaging students in competitions, healthy eating and alcohol awareness campaigns.

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- The proactive use of the community matron in end of life care planning, hospital admission prevention work promoted positive outcomes for patients. This included use of personalised care plans to ensure individual patient needs were met in the planning and delivery of their care.
- A patient singing group was held on a monthly basis since August 2013. This group comprised of patients over 60 years (and their carers) who had a chronic illness such as Alzheimer's and memory problems. This activity was aimed at improving the mental wellbeing of older patients.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

We found the practice had reliable risk management processes and this covered areas such as: safeguarding, medicines management, cleanliness, infection control and the maintenance of suitable equipment. Staff could describe what constituted abuse and knew how to recognise signs of abuse in older people, children and vulnerable adults.

Staff we spoke with understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Records showed the practice promoted learning and improvement from safety incidents. This included information about safety being recorded, reviewed and addressed in clinical governance and staff meetings.

Appropriate recruitment procedures were implemented to ensure suitable staff were employed, and there were enough staff to keep people safe. Overall, the practice maintained a safe track record over time and risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

We found the clinicians led on specialist clinical areas such as prescribing, dispensing, diabetes, and training. This allowed the practice to continually review best practice guidelines in relation to the assessment and management of specific conditions. The practice had effective systems in place to ensure that all clinicians were up-to-date with NICE guidelines and evidence based practice; and we found these guidelines were influencing and improving patient outcomes.

Patient needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Comparative data from the Clinical Commissioning Group (CCG) and Referral and Medicines Management Team (RMMT) showed the practice was performing highly when compared to some practices in the CCG area.

The practice used innovative and proactive methods to improve patient outcomes and engaged with other practices to share best practice. Multidisciplinary working and engagement with local community groups and schools was evidenced. Staff had received appropriate training relevant to their roles and further training needs were identified and planned for. Regular meetings were held

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between the practice, Patient Participation Group (PPG) and members of the National Association for Patient Participation to assess and monitor the service delivery. The PPG is made up of practice patients and staff, and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice.

Are services caring?

Good

The practice is rated as good for providing caring services.

We received positive feedback from patients in relation to the way staff treated them and involved them in decisions about their care. Patients felt the practice offered excellent care and staff were very pleasant and helpful. This was also reflected in most of the data and statistical information received from NHS England, the GP patient survey, Public Health England, NHS Choices and Healthwatch.

We found the practice was considering the bronze dignity award as part of a campaign aimed at putting dignity and respect at the heart of services that care for people. We observed a patient centred culture where staff treated patients with compassion, kindness and respect. People's privacy and confidentiality was also respected.

Accessible information was provided to help patients understand the care available to them. Patients and their carers were encouraged to participate in the decision making related to their care and treatment; and reasonable adjustments were made when required. This included access to longer appointments for population groups such as people with learning disabilities, mental health needs and communication difficulties.

The practice employed a community matron and a care coordinator whom together with the GPs were actively involved in the care planning for older people and people with long term conditions for example. Every patient aged over 75 years and seriously ill patients had a named GP to ensure continuity of care, and to reduce unnecessary emergency admissions to secondary care. The practice and the Patient Participation Group (PPG) facilitated events to help patients and their carers, to access services that could help them cope emotionally with their care and treatment.

Are services responsive to people's needs?

Outstanding

The practice is rated as Outstanding for responsive.

The practice was part of the initial pilot site for the Productive General Practice (PGP) programme which was designed and

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developed by the NHS Institute for Innovation and Improvement. The PGP helps practices to put the patient, clinician and practice team at the centre of improvement; to create a timely, appropriate and dependable response to patient needs.

As a result of this programme and ongoing improvement work the practice had initiated positive service improvements for their patients that were over and above their contractual requirements. This included quick implementation of new clinical guidance to improve patient care. The practice made changes to the way it delivered services including the appointment system as a consequence of feedback from the Patient Participation Group. Most patients we spoke with reported good access to the practice and a named GP or GP of choice, with continuity of care and urgent appointments available the same day.

The practice regularly reviewed the needs of the local population and was actively involved with the Clinical Commissioning Group and Primary Care Development Group to ensure service improvements where these had been identified. The practice had suitable arrangements in place to ensure the premises were adequately maintained and well equipped to treat patients and meet their needs. There was an effective complaints system available and patient complaints were responded to appropriately. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as Outstanding for well-led.

We found the practice had a strong team of clinical and non-clinical staff who worked towards developing each other's strengths and creating an environment in which clinical excellence could flourish. There was evidence of team working across all roles, and a high level of staff engagement in the planning and monitoring of services provided. Staff told us they felt valued and a system was in place to recognise and reward long service by staff. Patients we spoke with felt the practice was well managed, and that leaders listened and responded to their views.

The practice had an active Patient Participation Group (PPG). The PPG is made up of practice patients and staff, and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice. We found patient feedback was regularly sought to improve health services and empower patients to share decision making about their own care.

The practice had a clear vision with one of its priorities being to provide safe, effective and evidence based healthcare to all

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registered patients. The strategy to deliver the practice's vision and aims had been produced with stakeholders such as the NHS England, North East Derbyshire Clinical Commissioning Group and local community groups. The practice vision and aims were regularly reviewed and discussed with practice staff to promote ownership and delivery of good outcomes for patients. Governance and performance management arrangements were proactively reviewed and took account of current models of best practice. We found the management team was forward thinking and used learning from pilot projects and research to improve services for patients.

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The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people.

The practice served a high older population and had a very good understanding of the needs of older people. The older population group comprised of 19% of total patients registered at the practice; and this is 2% above the practice average across England. The North Derbyshire (North East locality) health profile also highlighted two significant characteristics of the older population served by this locality. This is, the lower life expectancy at 65 years for both men and women but a significantly higher population over 65 living in residential care.

Examples of outstanding practice took account of these characteristics and included the following:

The practice was involved with local community initiatives to reduce unplanned hospital admissions. For example, the GP and / or practice nurse referred older people with their consent to the Bolsover Wellness programme; which was delivered from the practice. This programme aims to increase levels of physical activity and promote improvements in mental health, long term limiting illnesses, the mobility and independence of older people. Some of the activities undertaken at the practice included chair-based exercise classes, of which we saw taking place on the day of our inspection.

The practice used a “personalised care plan” developed by practice staff for recording and reviewing vital health information for patients identified as being at high risk of hospital admission and / or have end of life care needs. We were told a copy of the care plan was kept in the patient’s own home and shared with other providers involved in their care. This included care home staff if they were a resident and the out of hour’s service (Derbyshire Health Limited) to ensure that the planning and delivery of each patient’s care was in line with their assessed needs.

A patient singing group was held on a monthly basis since August 2013. This group comprised of patients over 60 years (and their carers) who had a chronic illness such as Alzheimer’s and memory problems. This activity was aimed at improving the mental wellbeing of older patients.

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People with long term conditions

Good

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

The North Derbyshire area health profile showed there was higher than the England average number of patients with chronic heart disease, stroke, arterial fibrillation, hypertension, obesity, diabetes, COPD, asthma, chronic kidney disease, cancer and hypothyroidism living in the area covered by the Clinical Commissioning Group. For this reason we looked at services provided to patients with some of these conditions.

An example of outstanding practice included improvement work related to preventing and / or reducing unplanned admissions for patients with long term conditions; in line with the Clinical Commissioning Group priorities. For example, the community matron undertook a focused piece of preventative work with housebound patients. We found GPs undertook clinical audits and held regular clinical meetings to assess how they were performing when compared with best practice guidance and clinical standards.

There were support systems in place for carers, including a planned carer event organised by the practice and Patient Participation Group for 25 October 2014.

Weekly clinics led by the practice nurses were held to ensure the practice responded to this population group's health needs. The clinics related to conditions such as secondary prevention heart attack, diabetes, asthma and INR monitoring checks for patients taking warfarin. The training needs of practice nurses were also aligned to the health needs of this population group.

Systems were in place to ensure patients had structured annual reviews to check that their health and medication needs were being met.

Families, children and young people

Outstanding

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

The practice took into account the needs of young people in line with the Department of Health "quality criteria" for young people friendly health services; also known as "You're Welcome initiative. This included having leaflets in appropriate formats for young people displaying the services offered and how to access them; an explicit policy and information on confidentiality and consent for young people. The results of the practices' young persons (13 to 19 year old) questionnaire showed all participants would recommend the practice to others, felt staff were welcoming and friendly, and could ask questions.

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The use of facebook and twitter accounts was actively promoted by the practice so as to maximise interaction with young people about their health and medicines. The practice also engaged with the local schools to promote healthy eating and alcohol awareness. The practice website also had a section on “teen health” signposting patients to additional resources on sexual health and drugs for example.

We found immunisation rates ranged between 93% and 100% for all standard childhood immunisations; and this was in line with vaccination coverage for the north east locality which is above national average. There were robust review and recall systems for children with long term conditions such as asthma

Patients in this population group could access the citizens’ advice bureau (CAB) weekly sessions at the practice. The CAB helps people resolve their legal, money and other problems by providing advice and information, and by influencing policymakers.

Working age people (including those recently retired and students)

Good

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

The practice had identified the needs of this population group and had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included offering: telephone consultations, extended opening hours from 6.30pm to 8.00pm on Tuesdays and Thursdays at the Bolsover surgery, online services including prescription requests and introducing some on-line appointment booking mainly for evening surgeries. There was a range of information available to working patients or those who had recently retired in the practice and on the practice website.

The North Derbyshire (North East locality) health profile showed that the levels of incapacity due to chronic ill health in the working age population will play through into later life. Therefore a need to equip patients with the confidence to self-manage their health conditions. For this reason we looked at a range of health promotion and screening services provided to patients within this population group.

We found a cardiovascular risk assessment clinic was run by the practice nurses with the aim of advising patients on a healthy lifestyle and disease prevention. At these clinics blood pressure checks, weight advice and cervical smear testing were also offered. A family planning clinic was also offered including coil fitting,

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emergency contraception and advice about the menopause – including hormone replacement therapy. Health checks were also promoted for newly registered patients and for people aged 40-75 in line with NHS initiatives.

People whose circumstances may make them vulnerable

Good

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

One of the GP partners is a DOLS (Deprivation of Liberty Safeguards) mental health assessor having been approved under section 12(2) of the Mental Health Act 1983, as having suitable experience in the diagnosis or treatment of mental disorder. The GP's expertise was shared with staff when required to ensure some of the registered patients living in care homes were not deprived of their liberty.

A whiteboard recording system was in place to ensure all staff were aware of patient's in vulnerable circumstances due to their social and / or health conditions; and that appropriate support was provided when required.

The practice participated in multi-disciplinary working in the case management of vulnerable people. This included the community matron, community learning disability facilitators, residential care home staff and the local authority. There were effective re-call systems to ensure patient reviews and follow-up of referrals were undertaken in a timely way.

The practice was working towards the requirements of the government's enhanced service (ES) for people with learning disabilities. Clinical staff we spoke with demonstrated awareness of the standardised Cardiff Health Check templates, pre-health check questionnaire available from the royal college of general practitioners and the importance of making "reasonable adjustments".

Reasonable adjustments in place included longer appointments with the practice nurse followed by the patient's usual doctor; delivery scheme for medicines based on need not age, eat and treat, easy read information appropriate to an individual and their carer's needs.

The practice was considering the bronze dignity award as part of a campaign aimed at putting dignity and respect at the heart of services that care for people. Evidence to be submitted for this award included the reasonable adjustments made for patients in vulnerable circumstances.

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People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations including the local library, as part of the Reading Well Books on Prescriptions scheme.

This scheme involves the GP recommending a self-help book as part of the patient's treatment. There is good evidence from the National Institute for Health and Clinical Excellence (NICE) that self-help books can help people understand and manage common conditions including depression and anxiety, and this is supported by the department of health and Royal College of General Practitioners.

The practice was also involved in improvement work related to literacy including amendments being made to the practice's standard letters to make them easier for the patients to understand.

We found evidence of effective coordination of community-based mental health care for patients. This included onsite access to counsellors and a phlebotomist, advance care planning for patients with dementia and clinical audits related to the antipsychotic use of medicines for patients with dementia.

People experiencing poor mental health received an annual physical health check. Effective systems were in place to follow-up patients who attended accident and emergency (A&E) where they may have been experiencing poor mental health.

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What people who use the service say

Most of the 12 patients we spoke with expressed high levels of satisfaction with the care they had received and felt the practice was well managed. This was also reflected in the seven written comments we received on CQC comment cards and via Healthwatch. Positive comments given by the patients related to the following key areas;

- systems in place to support carers including providing emails about carer group meetings,
- services provided to meet the care needs of disabled children and their parents,
- availability of both early and late appointments, including same day and emergency appointments,
- staff being caring, helpful and involving patients in decisions about their care and treatment.
- and practice staff being responsive to concerns and complaints.

The PPG member we spoke with told us the practice leadership actively engaged with the group, and outcomes from meeting discussions and surveys were implemented to improve patient experience and health needs. Four out of the 12 patients we spoke with felt improvements were still required to reduce: waiting time in the surgery and the length of time to get an available appointment with a GP of their choice.

The results from Public Health England showed that 95.5% of patients would recommend their practice and 80.5% reported a good overall experience of making an appointment. These percentages were above the practice average across England of 79.2% and 78% respectively.

We spoke with a care home manager that has older patients registered with the practice. The manager was very complimentary about the care and treatment provided for the residents. They told us the same GPs visited which ensured a continuity of care and this was important for the residents. The community matron was reported as working well with the care home in planning and coordinating residents care to ensure they received appropriate treatment and support.

Outstanding practice

- This practice had a clear vision and a strong learning culture and were committed to continued quality improvement, including working with the productive general practice programme. This culture was embodied by all of the staff.
- A drive by the whole practice team to constantly innovate and improve the services it provides for its patients'. This included initiatives to promote patients physical and mental health wellbeing. For example, promoting adult literacy for patients with mental health needs and Bolsover Wellness (working with health trainers, providing onsite gym facilities, chair-based exercise classes and facilitating a falls prevention group).
- The practice promoted work with young people and schools as part of "You're welcome initiative". This included engaging students in competitions, healthy eating and alcohol awareness campaigns.
- The proactive use of the community matron in end of life care planning, hospital admission prevention work promoted positive outcomes for patients. This included use of personalised care plans to ensure individual patient needs were met in the planning and delivery of their care.
- A patient singing group was held on a monthly basis since August 2013. This group comprised of patients over 60 years (and their carers) who had a chronic illness such as Alzheimer's and memory problems. This activity was aimed at improving the mental wellbeing of older patients.

Dr M. R Spencer & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included the CQC Central Region GP Advisor, an Expert by Experience, two specialist advisors; a GP and Practice Manager. They were all granted the same authority to enter Dr M. R Spencer & Partners practice as the CQC Inspector.

Background to Dr M. R Spencer & Partners

Dr M. R Spencer & Partners (also known as Welbeck Health Centre) provides a primary medical service to patients living in and around Bolsover, Derbyshire. The practice has a branch surgery in Glapwell. Dr M. R Spencer & Partners is one of 38 member practices within the North Derbyshire Clinical Commissioning Group (CCG).

The CCG serves a population of approximately 288,000 people and some of its priorities include patient experience, integration of care, prevention and primary care transformation. The practice has a patient list size of about 11 000 people, and an approximate ethnic breakdown of 97% White British, and 3% Other. Most of the patients accessing the service fall within the working age and recently retired population of 19 to 74 years. The health centre is a GP training practice and offers a medicines dispensing service. The GP partners undertake the out of hours cover together with Derbyshire Health United Co-operative.

For this inspection, we only visited the health centre in Bolsover as the provider was previously inspected in December 2013. The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

We found 40 staff members were employed at the time of our inspection. This comprised seven GP partners, two salaried GPs and two GP registrars. The nursing team included a nurse practitioner, three practice nurses, one health care assistant and a phlebotomist. The dispensary team included a manager, four full-time dispensers and two dispensary receptionists. The administration team comprised of a practice manager, secretary, twelve reception and administration staff and an office junior.

The practice also worked with attached staff providing community services at the Bolsover surgery. This included a community matron, health visitors, school nurses, district nurses, counsellors, a health trainer, podiatrist, physiotherapist and clinicians facilitating heart failure, audiology and respiratory clinics.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. 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.

Detailed findings

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

How we carried out this inspection

To get to the heart of patients' experiences of care 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
- The working-age population and those recently retired (including 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 we hold about the practice and asked other organisations to share what they knew. This included NHS England Local Area Team, North East Derbyshire Clinical Commissioning Group and Healthwatch. We carried out an announced visit on 7 October 2014. During our visit we spoke with a range of staff (GP partners, nurse practitioner, community matron, dispensary staff, practice manager, reception and administration staff) and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed a range of records. We reviewed seven written responses where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included incidents within the practice, national patient safety alerts, clinical audits, as well as comments and complaints received from patients. The information was regularly discussed at practice meetings to ensure all staff were involved in highlighting and mitigating risks to patient safety.

We reviewed incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report and record incidents and near misses. They also told us they felt listened to, and their views and suggestions for improving patient safety were taken seriously.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring safety incidents in a timely manner. Staff we spoke with aware of the system and felt the leadership took appropriate action to investigate and promote learning from safety incidents. Records were kept of significant events and incidents that had occurred within the practice and these were made available to us. There was evidence that appropriate investigations had been undertaken and the findings were shared with relevant staff.

The clinicians also undertook clinical audits in response to safety incidents as part of their on-going quality improvement work. Where learning had been identified, this had informed changes to policies and procedures for relevant staff. For example, dispensary staff we spoke with were able to give examples of errors made, the learning and the resulting improvements made to improve patient safety. There was a system in place to monitor the effectiveness of improvements made as a result of the learning.

Reliable safety systems and processes including safeguarding

Patients were protected from the risk of abuse, because the practice had robust systems in place to identify and prevent abuse from happening. We found the provider had policies and procedures in place for child protection, safeguarding vulnerable adults and whistleblowing. These were shared with staff to ensure they were aware of the procedures to follow, if they needed to report a concern including safeguarding issues. A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by nursing staff and staff we spoke with understood their responsibilities when acting as chaperones.

The practice had GP leads for safeguarding children and vulnerable adults, and they had received the appropriate level of training to enable them to fulfil this role. Staff we spoke with were aware who these leads were, and their responsibilities regarding information sharing and documentation of safeguarding concerns. Training records we looked at showed staff had attended mandatory safeguarding training at a level relevant to their roles.

There was a system in place to flag at risk patients (children and vulnerable adults) on the practice's electronic records to ensure staff were aware of any relevant issues when patients attended appointments. A named GP was responsible for documenting and reviewing the patient notes to ensure they remained relevant. This included updating information shared at multi-disciplinary meetings relating to child health and vulnerable adults, and where patients had missed their recall appointment.

Patients' individual records were written and managed by authorised staff in a way to help ensure safety. Patient records were kept on an electronic system (SystmOne) which collated all communications about the patient's care and treatment. The patient notice board, website and booklet contained information making people aware of how their personal information was stored and maintained confidential. Overall, we found the provider had secure systems in place for the storage, retention and disposal of confidential records. Practice management records including staff records were kept securely in areas restricted to staff, and were promptly provided when requested during the inspection.

Medicines Management

The practice had appropriate arrangements in place for the following processes related to medicines management: obtaining, recording, handling, safe keeping, dispensing

and disposal. For example, medicines we looked at were stored at the recommended temperatures and were within their expiry date. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had a close working relationship with the local Referral and Medicines Management Team (RMMT), and received positive annual reviews in relation to their medicines management. The practice was involved in the local medicines management programme which included addressing clinical variation through RMMT visits, and we were told this work had resulted in very significant financial savings to the practice. There were GP leads for medicines management processes such as dispensing and prescribing; and spot checks were undertaken by the GPs to ensure patient safety and welfare.

The practice dispensed medicines to about a third of its registered patients and also provided a delivery service for housebound patients. Patients could pick up their dispensed medicines at the main surgery in Bolsover; and systems were in place to monitor how these medicines were collected. Appropriate information in relation to the prescription and dispensary services provided was displayed on the practice website, booklet and inside the premises.

Prescriptions were reviewed and signed by a GP before they were given to the patient. There was a protocol for repeat prescribing which was in line with national guidance. Dispensing staff were aware prescriptions should be signed before being dispensed and we observed this process was working in practice. Staff told us any errors noted on a prescription were immediately dealt with by the relevant doctor and the GPs were regarded as approachable when this needed to be addressed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Staff involved in the dispensing process had received appropriate training and had regular checks on their competence. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

The practice monitored repeat prescribing for patients receiving medication for mental health needs and / or long term conditions to ensure they remained appropriate. This included use of colour coding for scheduling medicine reviews / recalls, and discussions at clinical meetings on patients prescribed specific medicines such as analgesia and non-steroidal anti-inflammatory drugs (NSAIDs). NSAIDs are usually used for the treatment of acute or chronic conditions where pain and inflammation are present. The practice also used clinical audits to evaluate GP prescribing practices were in line with relevant guidelines and in response to medicine errors / alerts. For example, the practice had completed a half gliclazide tablet audit whereby the strength of the tablet prescribed and dispensed was reviewed.

The practice held stocks of emergency and controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and procedures were in place setting out how they were managed. These were followed by the practice staff.

Cleanliness & Infection Control

Patients we spoke with told us they had no concerns about cleanliness or infection control practices within the surgery. We observed the premises to be visibly clean and tidy. The practice had an infection prevention and control policy in place covering for example: hand hygiene, waste management, safe use and disposal of sharps, cleaning and decontamination of medical equipment. The policy and supporting procedures were available for staff to refer to, and enabled them to risk assess and prevent the spread of a health care associated infection.

For example, personal protective equipment including disposable gloves and aprons were available for staff to use and staff were able to describe how they would use them when handling blood/body fluids and dressings, in order to comply with the practice's infection control policy. Hand washing sinks with hand gel and hand towel dispensers were available in treatment rooms. The practice contracted out cleaning services of the premises and monitoring systems were in place to ensure appropriate standards of cleanliness and hygiene were maintained.

The nurse practitioner was the practice's lead for infection prevention and control. They had received relevant training to enable them to provide advice on the practice infection control policy, and carry out staff training. Infection control training took place for all staff as part of the practice's induction and thereafter on an annual basis. An annual audit and risk assessment of the practice's infection control procedures had been carried out to ensure best practice in

Are services safe?

line with NICE's infection control: Prevention of healthcare-associated infection in primary and community care. We saw that actions plans were implemented were improvements had been identified. The nurse practitioner was able to give examples of how significant events linked to infection control were discussed with staff, and the learning used to ensure patient and staff safety.

Equipment

Suitable arrangements were in place to ensure the safety, availability and suitability of equipment used in the delivery of patient care. The practice commissioned approved external companies to undertake portable appliance testing (PAT) for electrical equipment, calibration of medical equipment and servicing of fire extinguishers at both GP surgeries to ensure they were safe for use.

We saw records confirming that a calibration and a function check had been carried out on all relevant equipment in August 2014. This included weighing scales and thermometers. All portable electrical equipment was routinely tested and stickers indicating the last testing date were displayed. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Staffing & Recruitment

The practice had suitable arrangements in place to ensure there were sufficient numbers of staff to meet the patients' needs and the management of the practice. This included the use of a staffing rota system to determine clinical and non-clinical staffing levels based on a needs analysis of the service. The needs analysis included: reviewing patient demand for services – appointments, clinics, specific busy days of the week and times; as well as the administrative support required. There was also an arrangement in place for all members of staff to cover each other's planned and unplanned absences.

Staff told us there were enough staff to maintain the smooth running of the practice and there were usually enough staff on duty to ensure patients were kept safe. This was our observation on the day of the inspection. The management team acknowledged that actual staffing levels and skill mix had not always been in line with planned staffing requirements due to several members of staff being off sick at the same time. However, they were able to demonstrate how they had responded to unexpected staff sickness to ensure the delivery of a safe service. The practice was also recruiting for a dispenser at the time of our inspection.

Patients were cared for, or supported by, suitably qualified, skilled and experienced staff. The practice had a recruitment policy that set out the standards and processes it followed when recruiting staff. The staff records we looked at showed recruitment processes such as shortlisting and interviews had been carried out in the selection of staff.

Pre-employment checks had also been undertaken to ensure that; staff were of good character, had the necessary qualifications, skills and experience, as well as being physically and mentally able to do their job. The checks included proof of identity and eligibility to work in the UK, criminal record checks, satisfactory references, health checks and registration with the appropriate professional body for clinical staff.

Monitoring Safety & 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 purpose-built premises with service level agreements with estates for both sites, regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

Staff had access to panic buttons and keys on the computer in the event of an emergency. They were also aware of risks of lone working when undertaking home visits. For example we saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

The practice had also introduced a new system whereby the care coordinator flags up any unplanned admissions to the community matron; as well as hospital discharges on patients on unplanned admissions scheme. This was to ensure appropriate follow-up and coordinated care when the patient was discharged into the community. There were emergency processes in place for patients with long term conditions and experiencing a mental health crisis, including liaison with partner agencies such as the ambulance services, hospital and mental health teams.

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place for dealing with foreseeable emergencies that could affect the provision of services. A business continuity plan was in place covering how the practice would continue to be provided in the event of an emergency such as a fire and loss of utilities. Staff were able to give examples of how they were transported to work in adverse snow weather conditions. We saw records showing most staff had received training in basic life support and first aid awareness to inform their actions of how to respond to medical emergencies.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. Emergency medicines were securely kept and were available for use in the treatment of cardiac arrest, anaphylaxis and hypoglycaemia for example. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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 treatment approaches, and used template recording forms linked to specific care pathways to inform their assessment process. For example, we were shown records to demonstrate that assessed needs for cancer patients were undertaken in line with quality standards, issued by the National Institute for Health and Care Excellence (NICE) and the cancer care pathway. The resulting outcomes were regularly discussed at monthly care meetings.

Clinical meeting minutes and audits reviewed showed the practice took a proactive approach in reviewing patient assessed needs, to ensure good practice was reflected in their care and treatment. For example, the practice had identified the need for clinicians to improve their documentation relating to the type and severity of acne; following an audit that had identified that many clinicians had no clear guidelines before the acne pathway had been published.

The practice participated in monthly multi-disciplinary meetings and external peer review meetings to discuss current best practice guidelines, for assessing the needs of different population groups to ensure the welfare and safety of patients. This also helped to drive continuous improvement in achieving good health outcomes for patients. A good example included the assessment process and personalised care planning for older people at a local care home who were registered patients at the practice.

Assessments reviewed showed they were person centred, developed with them, with involvement of their family or staff and reflected their individual needs. The community matron and care coordinator collated information of patients admitted to the care home, and coordinated reviews based on their birthday month and every six months to ensure effective risk management of their health needs.

The community matron was proactively involved in end of life care planning for most residents in Millfield Nursing and Residential Home. The care home manager told us the continuous support received from the practice GPs, community matron and pharmacist contributed to good quality of care for the residents. This also included continuity of care as the same regular GPs visited, support in developing and reviewing residents' care plans, staff training from the community matron and joint working arrangements to improve the management of residents' medicines.

We were also shown examples of personalised care plans that had been agreed between the patient, GP, community matron and other professionals involved in the patient's care. In one case, the care planning process had improved the patient's quality of life in terms of their diabetes being better controlled and being less dependent on steroid medication.

The records relating to the 2013/14 North East Derbyshire North East Locality plan demonstrated how five practices including Dr M.R Spencer and Partners surgery aimed to ensure that resources were used in the most effective way to secure quality services where they were most needed. This included improving current services across the care pathway for dementia patients, including diagnosis, treatment and end of life services. We were told the practice had made savings of £83, 000 in relation to their medicines management quality improvement work and the effective monitoring of clinical variation in GP practice.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. This included GPs undertaking clinical audits linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national incentivised performance measurement tool. For example, we saw an audit regarding the fasting glucose levels in patients at high risk of diabetes development, and antipsychotic medicines used in dementia patients.

Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. Clinical meeting minutes reflected how GPs had evaluated the service and documented the success of any changes. We also saw records to evidence that the monitoring of hospital admissions for people over 65 years had resulted in a 1% reduction and the practice felt this was linked to integrated care arrangements with the local care home.

Good

Are services effective?

(for example, treatment is effective)

The practice also participated in local benchmarking run by the Clinical Commissioning Group. 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 comparable to other services in the locality. For example, in areas related to elective hospital admissions for urology, fractures, orthopaedic procedures and general medicine.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The practice had effective recall systems to monitor that patients attended for their medical reviews and health checks.

The practice made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. There was an expectation that all clinical staff should undertake audits as it informed the revalidation of their practice.

Regular meetings and events were facilitated with the Patient Participation Group (PPG) to review the effectiveness of service delivery including the appointment system. (A PPG is made up of practice patients and staff; and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice.

The PPG member we spoke with told us the practice leadership actively engaged with the group, and agreed outcomes and survey results were implemented to improve patient experience and health needs. This was reflected in the meeting minutes we looked at. Recent survey results and action plans were available on the practice website for reference.

Dr M. R Spencer and partners practice was highlighted as being an outlier in respect of the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months. An outlier means that the numbers of patients with this condition is high when compared with other practices. For this reason we looked at systems in place to address this.

We were shown template forms used by the clinicians to record alcohol consumption for patients with mental health needs in particular those with a diagnosis of schizophrenia. The recording template was linked to national guidance. Discussions with one of the GP partners showed while the practice was an outlier, this area of patient's health was regularly reviewed, and prompts within the electronic system were used by the clinicians to address relevant risks to individual patient's mental health.

Effective staffing

Practice staffing included medical, nursing, dispensary, managerial and administrative staff. The staff had defined duties they were expected to perform, and records showed they were trained to fulfil these duties. For example, practice nurses had relevant training in diabetes management, minor illness and family planning. The practice was proactive in funding in-house and external training; with staff being supported to attend national vocational qualifications, post graduate and leadership courses. All staff undertook annual appraisals which identified learning needs from which action plans were documented and reviewed.

A good skill mix was noted amongst the doctors, with each GP having special interests and additional qualifications in a specific area of medicine. For example, paediatrics, performing joint injections and minor surgery. GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). As the practice was a training practice, doctors who were in training to be qualified as GPs offered extended appointments and had access to a senior GP throughout the day for support.

Working with colleagues and other services

The practice worked with other service providers to ensure patients received safe and coordinated care. This included having robust systems in place for actioning any issues arising from communications with other care providers on

Good

Are services effective?

(for example, treatment is effective)

the day they were received. This included blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service which were received both electronically and by post. Staff we spoke with understood their roles and felt the system in place worked well.

The practice also had a care coordinator whose responsibilities included coordinating the care, treatment and support of patients, who had multiple health needs and received end of life care. This role was also informed by outcomes from multidisciplinary team meetings, where individual patient's needs were discussed. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice was commissioned for enhanced services and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract).

Information Sharing

The practice used a range of electronic systems to communicate with other providers and record patient information. For example, the practice used an electronic patient record (SystmOne) to coordinate, document and manage patients' care. There was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice had also signed up to the electronic Summary Care Record which provides healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. Patients were required to give consent for their clinical information to be included in the summary care record. Staff we spoke with were trained on the system, and commented positively about the system's safety and ease of use.

Consent to care and treatment

The practice had suitable policies and procedures in place for obtaining and acting in accordance with patient consent decisions in relation to their care. For example, written consent was sought for all joint / soft tissue surgical procedures. The consent form clearly detailed the procedure to be undertaken, relevant risks, benefits and whom to contact should the patient experience any side effects. Both the GP and the patient signed the form to confirm the discussion held and agreement to undertake the procedure.

The practice acted in accordance with legal requirements where patients did not have the capacity to consent due their age, disability and / or health condition. For example, we were shown examples of personalised care plans to evidence how best interest decisions had made between the patient, their relative and health professionals involved, to make a specific decision about an aspect of their care. This included decisions relating to end of life care and resuscitation for patients with complex care needs.

Staff we spoke with were aware of the Mental Capacity Act 2005 and Gillick competencies (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment); and their duties in fulfilling it. One of the GP partners is a DOLS (Deprivation of Liberty Safeguards) mental health assessor, having been approved under section 12(2) of the Mental Health Act 1983 as having suitable experience in the diagnosis or treatment of mental disorder. The GP's expertise was shared with staff when required to ensure some of the registered patients living in care homes were not deprived of their liberty.

Health Promotion & Prevention

These two programmes were also delivered in response to the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area and helps focus health promotion activity. The information showed that the Bolsover area has higher than average levels of income deprivation and long term conditions such as chronic heart disease, stroke and obesity.

The practice offered a full range of immunisations for children in line with current national guidance. Last year's performance for most immunisations was above average for the CCG area, and effective recall systems were in place to follow-up non attendees.

Information on health promotion was made available to patients via the website, leaflets in the waiting area, practice booklet and events facilitated with the Patient Participation Group. This included information on travel and teen health, specific health check clinics related to

Good

Are services effective?

(for example, treatment is effective)

smoking cessation, INR monitoring and family planning. There was a blood pressure monitoring machine available at reception to encourage patients to monitor their blood pressure. Patients could book an appointment with a clinician if the blood pressure readings were above the average. Other community services offered within the practice included podiatry, physiotherapy and clinics related to heart failure, audiology and respiratory.

A well person clinic for both males and females were offered with the aim of advising on a healthy lifestyle and disease prevention. Health checks were offered to new patients registering with the practice, patients aged 40-75 and where a need was identified to improve / maintain a patient's mental and physical wellbeing. This included structured annual reviews and case management for patients with learning disabilities, mental health needs and long term conditions. Effective re-call systems were in place to monitor patient attendance and ensure their welfare and safety.

Home visits were offered to housebound and / or older people who required flu vaccinations. The practice also used this opportunity to undertake reviews for patients with long term conditions such as diabetes and asthma. As a result of this initiative, the practice was able to demonstrate effectiveness in addressing patients' holistic needs, and also reduce the number of home visits required.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We found the practice was considering the bronze dignity award as part of a campaign aimed at putting dignity and respect at the heart of services that care for people. Staff we spoke with demonstrated awareness of providing patient centred care and ensuring that patients' individual needs were considered. We observed the positive use of language and interactions that demonstrated genuine respect for the patients.

We spoke with 12 patients on the day of our inspection including a member of the Patient Participation Group (PPG). This group is made up of practice patients and staff, and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice. All patients we spoke with gave positive feedback in relation to staff responding compassionately to their concerns, and their dignity and privacy being respected within the reception area and consultation rooms.

This was also reflected in the most recent data available for the practice on patient satisfaction. For example, data from NHS England GP Patient survey showed 89% of respondents stated the nurse was good at treating them with care and concern, and 82% in relation to the GPs. 85.4% of respondents also described the overall experience of their GP surgery as fairly good or very good. We received three completed CQC comment cards and four comments via Healthwatch. The feedback was positive about the service experienced. Healthwatch England is the national consumer champion in health and care. They have significant statutory powers to ensure the voice of the patients is strengthened and heard by those who commission, deliver and regulate health and care services.

Patients told us the practice offered excellent care, staff were very pleasant and helpful, and they were treated as an individual. We saw that patient consultations and treatments were carried out in the privacy of a consulting room. The doors were closed during consultations and conversations taking place could not be overheard. We observed staff were careful to follow the practice's confidentiality policy when discussing patient information to ensure it was kept private. Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

Staff told us 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 she would investigate these and any learning identified would be shared with staff. There was a visible notice in the patient waiting area, practice booklet and website stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us their health issues were discussed with them and they felt involved in the care and treatment they received. They also felt staff were attentive, listened to them 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 were also positive and aligned with these views.

In addition, patient survey information showed patients responded positively to questions about their involvement in care planning and making decisions about their care and treatment. For example, data from NHS England GP Patient survey showed 84% of respondents stated the nurse was good at involving them in decisions about their care; and 80% in relation to GPs. Furthermore, 81% of patients were noted as having comprehensive care plans agreed between individuals, their family / and or carers as appropriate.

The community matron was actively involved in the care planning of population groups such as older people, and people living with complex and long term conditions. We received positive feedback from the manager of a local care home the community matron and GPs visit. The manager told us the practice offered excellent care to the elderly residents. This included: continuity of care by the same GPs, adequate support in developing and reviewing residents' care plans including end of life care, and joint working arrangements to improve the management of resident's medicines.

Every patient aged over 75 years and patients with palliative care needs had a named GP to ensure continuity of care, and to reduce unnecessary emergency admissions to secondary care.

Interpreting / translation services were available for patients who did not speak English as a first language.

Good

Are services caring?

However, this service was not regularly used as the majority of the population spoke English. About 1% of the practice population were Polish and adjustments made included: the use of an interpreter when required, a double appointment slot (20 minutes instead of 10 minutes) and also stating this communication requirement when referring patients to the hospital. These adjustments ensured patients were involved as far as possible in all decisions affecting their care and treatment.

Patient/carer support to cope emotionally with care and treatment

The practice demonstrated a holistic and patient centred focus to meet not only patients' health needs but also their social and emotional care needs. This was achieved by working closely with local community groups. Patients and carers were signposted to a number of support groups and organisations via notices in the patient waiting room, practice booklet and website. This included Derbyshire carers association, social services and cruise bereavement.

Staff told us families who had suffered bereavement were called by their named / regular GP and a patient consultation was offered. The practice's computer system alerted GPs if a patient was also a carer. We were shown written information available for carers to ensure they understood the support available to them. The practice and the PPG had planned a carer's event for 25 October 2014 to promote carer services within the community and provide support where required. An open day for patients had also been held in May 2014 where health and social care stakeholders had attended including Crossroads Carers and Reading Well.

The practice facilitated a patient singing group on a monthly basis since August 2013. This group comprises patients over 60 years of age who have / or are suffering from any chronic illness such as Alzheimer's and memory problems (and their carers). The singing group is aimed at improving the mental wellbeing of older patients.

The practice offered special access facilities including a priority telephone line for patients and / or carers to contact the practice in the event of an emergency or to discuss the care being received. Annual reviews for population groups such as patients with learning disabilities and mental health needs were undertaken; with health action plans including emotional needs being reviewed and agreed.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Areas of outstanding practice we found included how the practice worked in partnership with a wide range of local community groups and services in promoting healthy lifestyles for patients; and in line with the Clinical Commissioning Group priorities for prevention work. For example, the Derbyshire Health Trainers and Bolsover Wellness Programmes were delivered from the practice and specifically aimed at increasing the life expectancy of patients within the area.

On the day of our inspection we observed patients participating in chair-based exercise classes, and patients we spoke with gave positive feedback about health promotion within the practice. The practice actively engaged with local schools to promote healthy wellbeing and lifestyle. This included healthy eating and alcohol awareness campaigns and competitions to promote participation.

The practice was actively engaged with partner agencies such as the Clinical Commissioning Group (CCG), Primary Care Development Group and four other practices within the local area (referred to as NEL5), as part of ongoing quality improvement work. The practice team had taken into account the population profile within the locality area to identify key factors that impacted on the delivery of their service. This included: deprivation within some Bolsover areas, increasingly elderly population (the practice female life expectancy is about 81 years and male 76 years) and a higher than the England average number of patients with a long term condition or with health conditions affecting their daily life.

Some of the work undertaken by the practice to respond and meet patient needs included: a proactive approach to multi-disciplinary care management which included employing a care coordinator and joint working arrangements with the attached community matron; in-house cardiac and pulmonary rehabilitation clinics facilities, and being quick to implement new clinical guidance. The practice also worked collaboratively with out- of -hour's services, hospitals and care homes. This included the sharing of information (special patient notes and personalised care plans) to ensure timely communication of changes in patient's care and treatment.

The practice was part of the initial pilot site for the Productive General Practice (PGP) programme which was developed by the NHS Institute for Innovation and Improvement. The PGP programme is a systematic approach to support practices in their drive to improve productivity, whilst meeting increasing levels of demand and diverse expectations. Staff we spoke with felt one key benefit of the PGP programme included promoting patient involvement in service delivery. For example, we found the practice had an active patient participation group (PPG) to help it engage with a cross-section of the practice population and obtain patient views.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. This included offering more telephone consultations and future plans to offer on-line appointments and additional GP surgery sessions pending recruitment. The PPG meeting minutes relating to these discussions and survey results were available on the practice website and within the surgery for patients to look at. A carer event had also been planned for 25 October 2014 to promote available service and support for carers.

Feedback from two patients we with spoke with and a written comment reflected that children and young people were treated in an age appropriate way, recognised as individuals and provided with good care. The practice actively promoted "You're Welcome" initiative. This is a Department of Health quality criterion for young people friendly health services. The practice had leaflets displaying the services offered and how to access them in appropriate formats for young people, an explicit policy and information on confidentiality and consent.

The results of the practice's own young person's (13 to 19 year old) questionnaire showed all participants would recommend the practice to others, felt staff were welcoming and friendly, and could ask questions. Improvements had been made by the practice to address the low response rates, relating to explanation of confidentiality and information about who can come with the young person. The use of facebook and twitter accounts were actively promoted by the practice to maximise interaction with young people about their health and medicines.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Tackle inequity and promote equality

The practice population compromised of about 97% White British and English speaking patients, with 1% of the practice profile being Polish and 2% classified as other. The practice had recognised the needs of different population groups in the planning of its services. This included use of translation services for patients whose first language was not English. Staff told us people from travelling communities / gypsies were able to register as temporary patients on a walk-in basis and where possible, on the day appointments were usually offered given some patients had no permanent address and needed support with reading written information.

The practice waiting area was large enough to accommodate patients with wheelchairs and prams, and allowed for easy access to the treatment and consultation rooms. The Bolsover surgery had easy access for disabled people and we were told that the Glapwell surgery may not be suited for some disabled patients. As a result, patients could always access the Bolsover surgery if needed. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice was situated on the ground and first floors of the building with services for patients on the ground floor.

Access to the service

Information about the practice's appointments system was available to patients on the practice website, information booklet and at the surgery. This included how to arrange home visits, pre-bookable and urgent / same day appointments. The Bolsover surgery offered extended hours up to 8.00pm on Tuesday and Thursday. The Glapwell surgery are: 08.30am to 10.50am and 3pm to 5.20pm on Monday, Tuesday and Thursday; and the surgery is closed on Wednesday and Friday afternoons.

We found suitable arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. This included accessing the NHS 111 service and emergency out- of- hour's service provided by Derbyshire Health United Cooperative. The Public Health England data showed 72% of respondents knew how to contact an out-of-hours GP service; which was above the practice average of 58% across England.

Most patients we spoke with were generally satisfied with the appointments system and a few patients felt improvements were still required, in regards to phone access and reducing waiting times. Patients also told us they could see a doctor and / or nurse on the same day if they needed to, and sometimes had to pre-book an appointment to see the doctor of their choice. This was also reflected in some of the written feedback we received from Healthwatch and on CQC comment cards. On the day of inspection we found there was availability for patient appointments during the day. There had been very little turnover of staff during the last five years which enabled good continuity of care and accessibility to appointments with a GP of choice.

In addition to the patient feedback we also reviewed data from the Public Health England. The data showed most patients could easily access appointments that were convenient for them. For example, about 88% of respondents were satisfied with phone access, 91% were satisfied with opening hours and 81% reported a good overall experience of making an appointment.

A comparison of performance in all these values showed the practice performed above the practice average across England. We also noted that the Public Health England findings were similar to the NHS England GP Patient survey results. For example, 82% of patients were satisfied with the practice opening hours and 92% gave a positive answer to the question "Generally, how easy is it to get through to someone at your GP surgery on the phone?"

The practice had a designated staff member responsible for coordinating and monitoring the appointment system and clinician's availability in real time (the actual time during which a process or event occurs) and on a daily basis. We found monitoring the appointment system in real time was an example of outstanding practice. It enabled the management to: actively respond to patient demand for appointments, make immediate changes to clinicians schedule to balance their appointment work load for the day and organize appointments more effectively.

To ensure that the appointment requirements for different individuals / population groups were met, we found examples of reasonable adjustments made. These included:

- Home visits for older people and housebound patients due to physical and / or learning disabilities, frailty and mental health needs.
- Flexible appointments for postnatal exams, baby checks, contraception and immunisations as well as appointments outside of school hours.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Extended opening hours at the Bolsover surgery for patients with work and / or school commitments. This is also a contractual requirement of their General Medical Services (GMS) contract. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.
- Longer appointments when needed. For example double slot appointments for when an interpreter is used and when undertaking annual reviews for patients with learning disabilities and mental health needs.
- GP and nurses offering more consultations to their normal working day if patient demand is high.

Listening and learning from concerns and complaints

The practice had clear procedures in place for receiving, handling and responding to patient concerns and complaints. This included: accessible information on how to make a complaint being displayed in the waiting area, practice information booklet and website. The complaints policy was available in English and staff informed us they could access an interpreter and / or translator if required.

Most of the patients we spoke with told us they knew how to complain if they had to, and felt comfortable to raise any concerns with staff. One of the patient's told us their complaint had been responded to appropriately. A suggestion box and "Tell us what you think leaflets" were visibly displayed in the waiting room area to encourage patients to have their say. Staff we spoke with demonstrated awareness of how to advise and support patients if they wanted to make a complaint or suggestion. The citizens' advice bureau held weekly sessions within the practice and additional information on advocacy services was also available to patients.

The practice manager was responsible for handling all complaints. We asked for and received a summary of complaints patients had made within the last 18 months. We found individual complaints had been acted upon in a timely way and a written response was provided to the patient. The practice undertook a complaints audit and the learning from the findings were implemented to improve the service. For example, complaints regarding difficulty accessing an appointment resulted in a review and changes of the appointment system where required; and complaints related to staff behaviours were discussed with them as part of their supervision, and also linked to the teams quality education and study time sessions (QUEST refers to protected time for team development).

Staff told us complaints were openly discussed to ensure all staff were able to learn and contribute to any improvement action that might be required; and this was reflected in some of the records we looked at.

Are services well-led?

Outstanding ☆

(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 of being patient focused and responsive to people's health needs when planning, reviewing and delivering its health services. We found details of the practice vision and aims were part of the practice's business plan, and were also linked to the North East Derbyshire Clinical Commissioning Group priorities.

The practice aims included: providing a high standard of medical care in a friendly and professional manner; improving patient experience, outcomes, health and wellbeing; and delivering improvements through innovative practice. Records we looked at showed the practice vision and strategy were also informed by evidenced based practice, patient and staff feedback, and collaborative working with four other practices within the north east locality (This peer group is referred to as NEL5).

Staff we spoke with demonstrated ownership of this vision and were aware of their responsibilities in relation to achieving positive outcomes for patients. The entire practice team regularly monitored and reviewed its progress against delivering the vision and strategy. The examples given by the leadership demonstrated understanding of the challenges the practice faced in terms of delivering good quality care, and actions needed to address them.

This included: succession planning and developing a new management structure in response to anticipated funding and workforce changes (GPs in particular); and the provision of integrated care due to an increasingly aged patient population, and patients with long-term conditions in the former mining community.

Governance Arrangements

The practice had a robust governance framework in place to support the delivery of good quality care. This included the use of policies and procedures to govern specific activities / services offered by the practice. Policies and procedures were reviewed by the practice leadership to ensure they remained up to date and were consistently implemented by staff. The policies we reviewed were in date and included patient confidentiality, data protection, quality improvement activities, staff recruitment and professional development.

The leadership told us they used the NEL5 meetings as part of a peer review process to assess patient needs and risk, and this informed the delivery of innovative programmes to improve patient outcomes. For example, the five practices involved "have agreed to develop a learning set type of approach to share existing best practice, review evidence and look to build a multi-disciplinary approach" in the delivery of care for patients with long term conditions. The practice leadership were also committed to an internal peer review process and worked towards reducing unwarranted clinical variation in GP practice. We found progress against this priority was regularly monitored to reduce health inequality and ensure effective care was delivered to patients.

The proactive engagement between the practice leadership and the Patient Participation Group (PPG) promoted patients views being considered when reviewing the practice's performance and quality improvement work. A PPG is made up of practice patients and staff; and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice.

The practice also used performance data to measure their service against others and identify areas for improvement. This included the use of Quality and Outcomes Framework (QOF) to measure their performance; and clinical audits to identify and manage risks. (QOF is an annual incentive programme designed to reward good practice).

We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes. The practice consistently maintained high QOF scores with the most recent data showing a total of 98% which is above the practice average of 96% across England. The North Derbyshire Clinical Commissioning Group described the practice as an achieving practice and proactive in terms of quality assurance.

Leadership, openness and transparency

The practice had a strong clinical and managerial leadership structure in place. This included seven GP partners, an experienced practice manager with senior members of the administration team for support, and a nurse practitioner who managed the nursing team. The practice leadership recognised the link between good leadership and good performance. As a result, GP partners and practice management were actively encouraged to undertake leadership courses, and to hold lead roles linked

Are services well-led?

Outstanding ☆

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

with patient outcomes and their experiences of accessing the service. This covered areas such as medicines management, the care and treatment of younger people, safeguarding, infection control and complaints.

The lead staff were accountable for their role in service improvement and produced audits / management reports for discussion as a team. We saw from minutes that team meetings were held at least monthly and informal meetings on a daily basis. We were invited to join the clinicians during their "coffee morning break" and staff we spoke with felt this was an effective forum for peer discussion and support. Non-clinical staff told us there was an open culture within the practice and they had the opportunity to raise issues at team meetings.

The GP partners and managers we spoke with expressed their motivation to ensure that patients received good quality care and that staff maintained job satisfaction. Staff we spoke with were clear about their own roles and responsibilities and they told us the service was well managed. Most of the long servicing staff had received gifts as an appreciation of their dedication and loyalty to the practice.

Staff also told us that participating in the Productive General Practice (PGP) programme promoted an open culture where staff evaluated existing services, agreed improvement areas; and as a result this enabled the team to develop better services for the patients and improve the productivity of the practice. The PGP was developed by the NHS Institute for Innovation and Improvement. This programme helps practices to put the patient, clinician and practice team at the centre of improvement to create a timely, appropriate and dependable response to patient needs.

Practice seeks and acts on feedback from users, public and staff

The practice had an active Patient Participation Group (PPG) which was fairly representative of the practice patient profile. The PPG group meetings are held at least every quarter and a virtual email PPG enabled more 18 to 34 year old patients to get involved. We spoke with a member of the PPG and they told us the meetings were well attended with up to 25 patients attending. The PPG member felt the practice staff listened and responded to patients' views and complaints, and that meetings were an effective forum for monitoring performance.

The practice gathered feedback from patients through patient surveys, comment cards and complaints received. The practice manager showed us the analysis of the most recent patient survey which was developed together with the PPG. The survey questions focused on alternative ways of consulting with a GP without seeing them in person. We saw that 67% of the 120 respondents confirmed having had a telephone consultation and 99% were satisfied with the service. As a result of this feedback and on-going review of the appointment system, the practice had increased its provision of telephone consultation appointments. Additional results and actions agreed from these surveys are available on the practice website. Information taken from Public Health England showed 95.5% would recommend their practice which is above the practice average across England.

The practice gathered feedback from staff during formal meetings, appraisals and informal discussions. Staff told us they could confidently give feedback on service provision and discuss any concerns with colleagues and management. For example, where pharmacy staff had evaluated that a specific training course was not relevant to their needs, alternative arrangements were made to ensure their development requirements were met. Staff told us they felt valued and engaged in the practice's quality improvement work. Team building events were also organised to boost staff morale.

Management lead through learning & improvement

The practice has a learning and development programme in place. This is informed by factors such as: the health care needs of the patients, skills and knowledge required by staff to carry out their roles, mandatory and professional registration requirements for clinical staff. Records we looked at showed this programme was regularly reviewed with staff as part of their induction, supervision and appraisal; and staff told us this promoted their professional development.

We found the practice has actively been involved in pilot projects over time; and as a result they had been quick to implement innovative changes to improve services for patients. For example, promoting adult literacy and working with Bolsover Wellness (working with health trainers, providing onsite gym facilities, chair-based exercise classes and facilitating a falls prevention group).

Are services well-led?

Outstanding ☆

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

The practice reviewed significant events and other incidents that occurred within the practice and shared the learning with staff to ensure the practice improved outcomes for patients.

Staff told us the practice was very supportive of their individual training needs and they were allowed protected time for team development. This included monthly training sessions named QUEST sessions (Quality Education and Study Time) and away days to focus on the service provision and future planning. Staff were enabled to acquire further qualifications that were relevant to the work they performed and patient health needs.

This included diplomas related to diabetes and minor illnesses for the practice nurses, and leadership courses to develop staff management skills. This was in line with the practice's aim of "supporting staff with on-going training", "developing strengths of other staff" and "to flourish in their roles". The practice is a GP training practice and they are regularly assessed for their suitability for postgraduate training in general practice by the local deanery. At the time of our inspection there were two GPs in training and two of the partners were GP trainers.