

Brailsford and Hulland Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brailsford and Hulland Medical Practice on 30 November 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, and appropriately reviewed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. This was kept under review by the practice which proactively used audit as a way of ensuring that patients received safe and effective care.
- Risks to patients were assessed and well managed. Regular liaison meetings were held with the wider multi-disciplinary team to co-ordinate the provision of effective and responsive care. There was good evidence of collaborative working including end of

life care and safeguarding. The Clinical Commissioning Group (CCG) pharmacist attached to the practice provided regular and effective support on medicines issues.

- All members of the practice team had received an annual appraisal and had undertaken training appropriate to their roles, with any further training needs identified and supported by the practice.
- Results from the national GP survey, and responses to our conversations with patients showed that patients were treated with compassion, dignity and respect, and that they were involved in their care and decisions about their treatment.
- Urgent appointments were available on the day they were requested and there was good access to routine appointments which could be booked up to a year in advance. However, patients said that they sometimes had to wait a long time for non-urgent appointments and to see their preferred GP
- There was a clear leadership structure and staff felt supported by management, although there was no clear vision for the future of the practice that had been shared with staff.

Summary of findings

- The practice proactively sought feedback from patients, which it acted upon and they had implemented changes as a consequence of feedback from patients and from the Patient Participation Group (PPG).

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

- Consider how their vision for the future of the practice is shared with staff
- Review the arrangements for cascading learning from significant events to try and prevent recurrence.

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?

The practice is rated as good for providing safe services. There was an effective system in place for reporting and recording significant events and learning was shared in monthly practice meetings in order to improve safety

When there were unintended or unexpected safety incidents, people received reasonable support, truthful information and a verbal and written apology.

The practice had clearly defined systems, processes and practices in place to keep people safe and safeguarded from abuse. Staff had received appropriate training and were clear about what to do if they had a safeguarding concern.

Risks to patients were assessed and well managed. Processes were in place to manage safety alerts and staff followed the practice's own processes. For example, when dispensing medicines, and managing incoming mail including test results.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality and the practice had achieved 97% of the available points within the 2014-15 Quality and Outcomes Framework.

Staff assessed needs and delivered care in line with current evidence based guidance. They had the skills, knowledge and experience to deliver effective care and treatment and had received training appropriate to their roles.

The practice had participated in clinical audits which had demonstrated quality improvement.

All staff had received an appraisal, had a personal development plan and were able to tell us what training they were to receive in the next year.

Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs. This included working with a care coordinator who assisted in planning care for people with complex needs, including social care.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care, for example 97% patients said the last GP they spoke to was good at treating them with care and concern

Good



Summary of findings

compared to the CCG average of 87%, and the national average of 85%. Patients also said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment

Information for patients about the services available was easy to understand and accessible.

We observed patients being treated with kindness and respect, and their confidentiality was maintained during their consultations. However, conversations could sometimes be overheard at the reception desk in the small waiting room.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.

Patients said they found it easy to make an appointment with a GP but that they sometimes had to wait a long time to see their preferred GP. Urgent appointments were available the same day for patients who requested one. They also saw patients who arrived on the day without an appointment if they lived a long distance away and those who were visiting the area.

The practice had limited space but had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with relevant staff

Good



Are services well-led?

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and support the delivery of good quality care and staff followed the practice's policies. This included arrangements to monitor and improve quality and identify risk.

The practice partners had a vision for the future of the practice and were developing a strategy in order to accommodate increasing list numbers, which they intended to share with staff

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

Good



Summary of findings

There was a strong focus on continuous learning and improvement, particularly for clinical staff.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people such as dementia, osteoporosis and coronary heart disease. The practice had achieved 100% of the available points in all of these areas which was above both the Clinical Commissioning Group CCG and national averages. For example, 95% of patients suffering with dementia had received a health check in the preceding year.

The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, specialised sessions for hearing aid issues, influenza, pneumonia and shingles immunisation sessions. They also provided community transport service to bring older people to the practice.

The practice offered home visits and rapid access appointments for those with enhanced needs. They were mindful that many of their older population were cared for by relatives and held a carers register and were alerted to a patient being a carer by a pop-up message on the patient's file. This reminded them to check on their welfare. Carers were also offered a seasonal influenza vaccination.

Regular meetings took place to review patients with unplanned hospital admissions and readmissions. Individual cases were discussed with the care co-ordinator and community nursing team, and where necessary with social services and the community mental health team. The practice used care plans for their most vulnerable patients including older people.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. All patients with a long term condition had a named GP. Nursing staff had lead roles in chronic disease management, for example in asthma and coronary heart disease, and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. One appointment was offered to incorporate the needs of patients with two or more chronic diseases to review the patient holistically and to prevent them having to attend more frequently than necessary.

Home visits were carried out for patients who were housebound and included providing blood testing and immunisations where required.

Good



Summary of findings

All these patients had a named GP and a structured annual review to check that their health and medicines needs were being met. For those people with the most complex needs, the named GP worked with a care coordinator and other relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. For example; The rates for children over the age of 24 months was slightly higher than the Clinical Commissioning Group (CCG) average but the rate for infants under 24 months was slightly lower than the CCG average.

Cervical screening was carried out for eligible people and those who didn't attend for an appointment were sent a letter or contacted by telephone to re-book their appointment. This resulted in 86% of patients being screened who were eligible for it. This was 2% higher than the CCG average and 4% higher than the national average.

Appointments were available outside of school hours and the premises were suitable for children and babies. There were examples of joint working with midwives, health visitors and school nurses. In particular, the community matron and health visitors liaised regularly with the GPs and the practice was able to alert any of the community support team to concerns about patients through the practice's computer system.

Good



Working age people (including those recently retired and students)

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice were able to provide blood testing at the practice and a dispensary was also onsite.

A range of appointments were available including later appointments for working people and telephone consultations on request.

Good



Summary of findings

The practice was proactive in offering online services and provided information and links to national services via their website. In addition the practice offered a range of health promotion and screening information that reflected the needs for this age group.

People whose circumstances may make them vulnerable

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

The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability. It offered longer appointments for people with a learning disability and annual health checks for all vulnerable people.

Vaccinations were offered to their vulnerable population and home visits were provided where required.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. This included working with a care coordinator who was able to assist in finding community resources to support patients and their families.

It had told vulnerable patients about how to access various support groups and voluntary organisations.

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

Good



People experiencing poor mental health (including people with dementia)

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

95% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. However, their exception reporting rate was 14% which was 5% above CCG average and 6% above the national average. (The exception reporting rate is the number of patients which are excluded by the practice when calculating achievement within QOF)

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia so that advance care planning could be carried out. They had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Good



Summary of findings

The practice offered an annual health review to all patients on their mental health register and had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. We saw a range of information leaflets in reception.

The practice had engaged in a 'Dementia Friendly Practice' scheme with the Alzheimer's Society and staff had a good understanding of how to support people with mental health needs and dementia. They had provided an information session for members of the Patient Participation Group (PPG) and reviewed the premises as someone with dementia. This had led to some changes within the building including changing some of the signs so that they were more suitable for people with dementia.

The GP lead for dementia had produced a dementia pack which was being used within the practice and for home visits. The practice had set aside time to complete annual health checks for people with dementia in the own home, where it was required.

Summary of findings

What people who use the service say

We reviewed the national GP patient survey results published on 2 July 2015. The results showed the practice was performing in line with local and national averages. There were 254 survey forms distributed and 156 were returned, which was a response rate of 61%

- 93% found it easy to get through to this surgery by phone compared to a CCG average of 75% and a national average of 73%.
- 96% found the receptionists at this surgery helpful (CCG average 88%, national average 87%).
- 94% were able to get an appointment to see or speak to someone the last time they tried (CCG average 87%, national average 85%).
- 97% said the last appointment they got was convenient (CCG average 92%, national average 92%).
- 98% described their experience of making an appointment as good (CCG average 74%, national average 73%).
- 65% usually waited 15 minutes or less after their appointment time to be seen (CCG average 69%, national average 65%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 35 comment cards, the majority of which were very positive about the standard of care received. In general, the comments cards described the practice as delivering an excellent, personal service, where GPs, clinical staff, attached staff and receptionists treated them with respect, were caring and kind and sensitive to their needs. The patients said they felt valued by the GPs and practice staff

Of the four negative comments received, two were related to making an appointment, one to staff attitude and one was related to a complaint which was being investigated by the practice.

We spoke with five patients during the inspection. All five patients said that they were happy with the care they received and thought that staff were approachable, committed and caring. They told us that they had no difficulty getting an appointment and most felt that they were given enough time during their appointment where they felt listened to.

Brailsford and Hulland Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Brailsford and Hulland Medical Practice

Brailsford and Hulland medical practice is situated in Southern Derbyshire and is an established rural general practice partnership caring for people living in Brailsford, Hulland Ward and surrounding areas. The practice currently operates from two sites: a main surgery at Brailsford and a branch at Hulland ward which is around five miles away. Patients are able to attend either the main practice or the branch surgery.

The practice currently has a patient list of 6,000 which may rise over the next few years due to the development of a large housing estate within the catchment area.

Currently the practice serves a population that has a deprivation score of 9 which is significantly lower than the national average for deprivation. The practice has a higher than average population of older people. For example 28% of its population are over 65 years and 12% are over 75 years.

The practice is run by a partnership of two GPs (one male and one female) and employs two salaried GPs who are both female.

All of the staff are part-time. There are three registered nurses who provide chronic disease management programmes as well as the usual treatment room services and anti-coagulant services for patients at the surgery and at home. (Anticoagulants are medicines that help prevent blood clots and are given to people at risk of getting clots. Regular blood sampling is carried out to monitor the level of medicine in the blood so that it can be adjusted). The clinical team is supported by a practice manager, an assistant practice manager and a team of 12 administrative, secretarial and reception staff. The practice also hosts the district nursing team employed by Derbyshire Community Health Services NHS Foundation Trust.

The practice has a General Medical Services (GMS), contract and provides a number of services including;

- Routine medical checks and general medical services
- Vaccinations and immunisations
- Foreign travel advice and immunisations
- Chronic disease management
- Family planning and contraception services
- ECG monitoring
- Hearing tests
- D-Dimer procedure to test for deep vein thrombosis (DVT)

Detailed findings

The practice is open between 8 am and 6.30 pm Monday to Friday at the Brailsford site on weekdays, and 8.30 am to 12 pm on Tuesdays, Wednesdays and Thursdays and from 2 pm to 6 pm on Mondays and Fridays at the Hulland Ward site. Appointments are available from 8.30 am to 11.30 am every morning and 3 pm to 6 pm every afternoon Monday to Friday at the Brailsford site. At the Hulland ward site appointments are available from 8.40am to 11.10 am on Tuesdays, Wednesdays and Thursdays and from 3.10pm to 5.40pm each Monday and Friday. Extended evening hours surgeries are not offered. Patients are able to book appointments at both surgeries either by telephone or online. Pre-bookable appointments could be booked up to one year in advance and urgent appointments are available on the same day for people that need them.

When the practice is closed patients are directed to Derbyshire Health United (DHU) via the 111 service. The website also provides details of the walk in centre and reminds patients to call for an ambulance in the event of an emergency.

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. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 30 November 2015. During our visit we:

- Spoke with a range of staff (GP Partners, practice nurses, dispensing staff, practice manager, receptionists and administration staff) and spoke with patients who used the service.
- Observed how people were being cared for and talked with carers and/or family members
- Reviewed the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. Staff told us they were encouraged to report significant events and would inform the practice manager of any incidents. For example, the Dispensing team had been commended by the Clinical Commissioning Group (CCG) for prompt action taken following identification of a medicines error. There was a recording form available on the practice's computer system.

The practice carried out an analysis of the significant events and discussed these at the monthly practice meeting where lessons were learned and good practice identified. We saw minutes of meetings where discussions had taken place and reviewed the significant events log where events were described and actions taken to prevent it from happening again. Information was shared with staff who had been involved

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep people safe, which included:

- Safeguarding arrangements were in place to protect children and vulnerable adults from abuse that reflected relevant legislation and local requirements. We spoke to staff who demonstrated they understood their responsibilities for safeguarding and all had received training relevant to their role. There was a practice safeguarding policy in place which outlined how to report concerns if any staff member observed or became aware of a potential or actual safeguarding issue. There was a lead GP with responsibility for safeguarding, and bi-monthly meetings took place to discuss and review safeguarding concerns with relevant practice staff and the attached health visitor and school nurse. The GPs also liaised regularly with the health visiting team regarding any safeguarding issues between meetings and were alerted to safeguarding concerns through the practice's computer system
- All staff who acted as chaperones were trained for the role and had received a disclosure and barring service check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred

from working in roles where they may have contact with children or adults who may be vulnerable). Patients who we spoke to and feedback from comment cards said that patients were always offered a chaperone and that staff were very good at providing this.

- We saw that there were safe systems to review incoming correspondence from the out of hours service and pathology laboratory results. The pathology results were reviewed daily by two GPs and any necessary actions were undertaken promptly and recorded. The results came to the practice electronically and were printed onto paper so that both partners could check the result before acting on it. The partners told us that this process enabled a fail-safe system so that no unusual result would be missed. They had assessed the risk of delay where the second partner may not be available on the same day to review the results and taken action to mitigate this. For example, another GP would be asked to act as second reviewer if one partner was absent.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. Maintenance of the building was managed via a contract with an external company. The practice told us that they had not carried out regular fire drills, however, they had an up to date fire risk assessment and there were smoke detectors in place. Staff told us they knew how to raise the alarm and what to do if fire was suspected. We saw records that all staff had received fire training in the last 12 months. Fire extinguishers were in place and we saw evidence that showed that these were checked regularly. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a range of risk assessments in place to monitor safety within the premises such as control of substances hazardous to health and legionella.
- We observed the premises to be tidy and kept to a good standard of maintenance. The practice was cleaned daily by an external company and staff were also responsible for cleaning designated areas. We saw there was a cleaning schedule in place and we saw that a cleaning schedule had been adhered to. Practice staff had designated areas to clean. Patients commented positively about the cleanliness of the practice, however, on the day we inspected, we found that the

Are services safe?

floor and skirting in the reception area had not been cleaned as thoroughly as the rest of the practice. We saw evidence to support the cleaning of medical equipment within the practice in line with the practice policy. A practice nurse was newly appointed to the role of infection control clinical lead in conjunction with an administration lead. There was an infection control policy in place which had been reviewed and amended in September 2015 and contained a number of protocols and references to other policies which were intended to maintain good infection prevention and control. A comprehensive assessment had been carried out in conjunction with the Infection Prevention and Control nurse specialist from Derbyshire CCG, which identified a number of issues and an action plan was created to address these. We saw that actions identified were in progress and others were acted upon immediately. For example;

- Fabric curtain screens were changed to paper curtains which were disposable
- Pump soap dispensers and alcohol gel dispensers were introduced
- Waste bins were changed to pedal bins.
- The practice showed us plans to conduct a handwashing audit in January 2016. They told us that all staff received training on infection control during induction and we saw evidence of this in the two files we looked at for the most recently recruited staff. We also looked at training records and saw that all staff had received their annual refresher training for infection control within the last 12 months.
- There was a system for posting requests for repeat prescriptions using a letter box in the reception area. Prescriptions could also be ordered online. The practice adhered to their own guidelines for handling monthly prescriptions and all regular prescriptions were reviewed annually. All staff who were involved in the handling of prescriptions were aware of the Standard operating procedures (SOP's) which were in place and were seen to be up to date. All of the seven dispensing staff were fully qualified, although this is not a mandatory requirement. The practice adhered to their own policy where two dispensing staff checked every prescription fulfilment prior to handing it to the patient, and that any controlled drugs (CD's) were also checked by a GP. Controlled drugs are prescription medicines that are controlled under the Misuse of Drugs legislation. We saw that the practice's storage of CD's

and stock checking was good. They described a CD error that had occurred and their actions to deal with it in a timely and appropriate way. The practice was commended by the CCG for their actions relating to this. The practice told us that the dispensing staff worked different shift patterns that enabled them to work with and support each member of the dispensing team.

- Vaccines were in date and kept in refrigerators which were monitored for temperature control twice daily and a log maintained. The clinical staff we spoke to told us that they knew what procedure to follow if the refrigerator temperature fell above the recommended temperature and gave an example of their actions in response to this
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). All members of the practice team had received appropriate clearance from the DBS. The practice had group indemnity cover for all the GPs and nursing staff.
- Arrangements were in place for planning the number of staff and mix of staff needed to meet patients' needs. The practice told us that they felt they had adequate staff to meet the needs of their patients and that this included utilising regular agency doctors who became familiar with the practice. Where staffing gaps occurred the team covered one another's shifts.

Arrangements to deal with emergencies and major incidents

The practice had a system in place to alert the team to emergencies and all staff received annual basic life support training. There were emergency medicines and a defibrillator and oxygen with adult and children's masks available on the premises and staff knew where to find these.

All the medicines and emergency equipment we checked were in date and fit for use

The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice routinely used National Institute for Health and Care Excellence (NICE) best practice guidance and other national and locally agreed guidelines and protocols as part of their consultations with patients. The practice had systems in place to ensure all clinical staff were kept up to date

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF), a system intended to improve the quality of general practice and reward good practice. The latest published results for 2014-15 were 97% of the total number of points available, which was the same as the CCG average and 3% above national average. The exception reporting was 10% which was similar to CCG figure of 11% and 1% above the national average. The exception reporting figure is the number of patients excluded from the overall calculation due to factors such as non-engagement when recalled by the practice for reviews. A lower figure demonstrates a proactive approach by the practice to engage their patients with regular monitoring to manage their conditions. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-15 showed;

- Performance for diabetes related indicators at 95% was better compared to the CCG average of 93% and the national average of 89%
- Achievement for mental health related indicators was 85% which was 12% below the CCG average and 8% below national average.
- Performance for indicators relating to secondary prevention of coronary heart disease was 98% which was better than CCG average by 1% and national average by 2%.

They also achieved 100% of available points for disease indicators which included; asthma, cancer, chronic kidney disease, dementia and depression

Clinical audits demonstrated quality improvement. There had been two clinical audits completed in the last two

years, both of these were completed audits where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example,

- Recent action taken as a result included an audit to identify the number of patients in the practice who had a diagnosis of gout but who had not received a risk assessment for cardio vascular disease (CVD) Gout is a form of acute arthritis that causes severe pain and swelling in the joints, most commonly affecting the big toe. All patients who had not received a CVD risk assessment were invited to receive a risk assessment and a consultation to discuss preventative treatment where required. This resulted in an increase in CVD risk recording from 0% to 66%
- An audit was undertaken to identify the number of patients being treated with steroid therapy who did not carry a steroid therapy card in case of emergency. The findings of the audit was that 77% of patients on long term treatment were carrying the card compared with 40% at last audit. Cards and letters were sent out to those patients who were identified as not carrying the card and those who had not responded to the audit request.

The practice participated in other local audits in accordance with CCG guidelines.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had a low staff turnover and most of the staff we spoke to had worked there for many years. We saw an induction checklist for one recently appointed non-clinical member of staff and saw that the induction had covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Clinical staff we spoke to told us that they had received an induction that lasted several months and felt that it had supported their practice.

All staff had access to appropriate training to meet their learning needs and to cover the scope of their work. In particular, clinical staff told us that the practice was very supportive in enabling them to attend courses to update their clinical knowledge and skills. They also told us that they received ongoing support during sessions and mentoring where required.

Are services effective?

(for example, treatment is effective)

Staff who had specific roles had undergone role-specific training and updating e.g. for those reviewing patients with long-term conditions such as diabetes and chronic obstructive airways disease (COPD), and for those administering vaccinations. (COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulties breathing, primarily due to the narrowing of their airways, this is called airflow obstruction.)

All staff received an annual appraisal in the last 12 months where their learning needs were discussed. We looked at four staff appraisal records and saw that appraisals had taken place and that learning and development was agreed and planned to some degree. However, documentation was brief and development plans not consistently clear.

We saw a training register that showed that staff received training that included: safeguarding, fire procedures, basic life support, anaphylaxis, bullying and harassment, chaperone training, gaining patient consent, and information governance awareness. All staff had recently received refresher training on information governance and dementia training. However, we saw that a number of staff had not completed annual refresher training offered for some of the non-mandatory training topics. Staff also made use of e-learning training modules, in-house training and external courses.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system, which was also accessible to attached staff. This included care plans, medical records and test results. On the day of our inspection we observed care plans for patients with a long term condition. The practice told us that care plans were discussed in meetings with appropriate staff and reviewed regularly. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they

are discharged from hospital. The two partners reviewed all patients who had recently been discharged from hospital and ensured that any new medicines were recorded in the patient record and the care plan amended where required. Particular attention was paid to patients with a learning disability, and patient with a mental health issue.

We reviewed meeting minutes and saw evidence that multi-disciplinary team meetings took place on a monthly basis and included GPs, practice manager, assistant practice manager, practice nurses, CCG pharmacist, dispenser, community matron, community nursing sister, care co-ordinator, district nurse, health visitor, midwife, palliative care nurse and where necessary with social services and the community mental health team. Care plans were routinely reviewed and updated and regular agenda was discussed including deaths, palliative care register, significant events analysis, and updating QOF data.

The practice had recently implemented a separate meeting to discuss safeguarding concerns which occurred every 2 months. This was led by the safeguarding lead and included the assistant practice manager, school nurse and health visitor.

Other meetings occurred to discuss practice issues. For example the two partners met weekly, the dispensary team met twice per year, the administration team met when required, the nurses met monthly and the patient participation group (PPG) met bi-monthly. There was also a quarterly meeting where non clinical staff could meet for training and development and clinical staff attended annually.

Consent to care and treatment

Clinical staff demonstrated a thorough understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

The practice identified patients who may be in need of extra support. These included patients in the last 12

Are services effective?

(for example, treatment is effective)

months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and those at risk of developing cardio vascular disease (CVD) There was information available to enable patients to know about services available to them. For example, diet advice, alcohol advice, sexual health advice and smoking cessation advice was available from local support groups.

The practice's uptake for the cervical screening programme was 86% which was higher than the CCG average of 84% and above the national average of 82%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example,

childhood immunisation rates for the vaccinations given to under two year olds ranged from 84% to 98% and five year olds from 95% to 100%. Flu vaccination rates for the over 65s were 74%, and at risk groups 52%. These were also comparable to CCG and national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people who were at risk of developing a chronic condition. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection, we found that delivering good patient care and a genuine desire to do the best for patients was at the heart of all the staff. This appeared to be part of their everyday work and the patients we spoke to told us that nothing seemed too much trouble.

We saw that members of staff were polite and helpful to patients both attending at the reception desk and on the telephone and people were treated with dignity and respect. Staff were able to move patients who wanted to talk about sensitive matters, or if they appeared distressed, into an area which had been created next to the reception desk to maintain their confidentiality.

Almost all of the 35 patient CQC comment cards we received were extremely positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, extremely caring and treated them with dignity and respect and told us that this related to GPs, nurses, attached staff and receptionists. Many of the patients who completed the cards told us they had been with the practice for many years and enjoyed the personal service that it offered. We also spoke with four members of the patient participation group who told us that they felt well supported and generally listened to by the practice, although they didn't always receive feedback on information they had provided for the practice. They were involved in the changes made to the reception area and had Dementia Friends training which was provided by the practice.

We observed that members of staff were courteous and very helpful to patients and treated people dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

In the national GP patient survey conducted in July 2015, 236 surveys were sent out and 147 were returned which is a response rate of 61% The results showed that the practice was above average for its satisfaction scores on consultations with doctors and nurses, For example:

- 97% said the GP was good at listening to them compared to the CCG average of 90% and national average of 88%.
- 97% said the GP gave them enough time (CCG average 88%, national average 87%).
- 100% said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%)
- 97% said the last GP they spoke to was good at treating them with care and concern (CCG average 87%, national average 85%).
- 97% said the last nurse they spoke to was good at treating them with care and concern (CCG average 91%, national average 90%).

The practice was rated better than average for getting help from reception staff. For example;

- 96% said they found the receptionists at the practice helpful (CCG average 88%, national average 87%)
- 100% described their overall experience of this surgery as good (CCG average 87%, national average 85%)

Care planning and involvement in decisions about care and treatment

Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told they felt listened to and usually had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 99% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.

Are services caring?

- 91% said the last GP they saw was good at involving them in decisions about their care (CCG average 84%, national average 81%)

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. For example;

- Living with terminal illness
- Alcohol advice

- Talking mental health.
- Carers association

The practice's computer system alerted GPs if a patient was also a carer which served as a reminder to check how they were managing. The practice had a formal register of carers at their practice and a receptionist had a lead role in ensuring that carers were registered and informed of services available to them in order to access help and support. Written information was available to direct carers to the various avenues of support available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was situated in a rural area and patients sometimes needed to travel a long way to be seen. They had reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice accommodated patients who called in to speak to a doctor whilst in the area. This was supported by patient comment cards

The practice told us that patients who wanted an urgent appointment were always given one as they took a patient led approach to making urgent appointments. There were longer appointments available for people with more complex needs such as some older people or those with a learning disability where this was required. Home visits were available for patients who would benefit from these. Appointments were available for working people from 5.30pm weekdays and telephone consultations were available on request.

Services that were regularly required such as phlebotomy (blood testing) and dispensing of medicine were made available at the surgery.

There were disabled facilities, hearing loop and translation services available if required.

The practice had a good knowledge of their patients and regularly discussed individual needs of patients who had complex needs, mental health needs, older people or those with a learning disability and health reviews offered where needed. This was reflected in the practice's usage of the out of hours (OOH) services which was lower than the CCG average.

The practice had engaged with the Alzheimer's Society to enable the practice to become 'Dementia Friendly' and had provided dementia training for members of the patient participation group (PPG).

Annual reviews were offered to vulnerable patients and those who needed them and a care coordinator was utilised to assist in finding community resources to support patients with complex needs and their families

Website links were promoted to young people to access information and advice on drug and alcohol services and sexual health.

The practice's dispensary staff provided special medicines packs to assist patients who had difficulty in managing their medicines.

Access to the service

The practice was open between 8 am and 6.30 pm Monday to Friday at the Brailsford site. At the Hullard Ward site the practice was open , and from 8.30 am to 12pm on Tuesdays, Wednesdays and Thursdays and from 2 pm to 6pm on Mondays and Fridays. Appointments were from 8.30am to 11.30am in the morning and 3pm to 6pm in the afternoon Monday to Friday at the Brailsford site. At the Hulland ward site appointments were available from 8.40am to 11.10 am on Tuesdays, Wednesdays and Thursdays and from 3.10pm to 5.40pm each Monday and Friday. Extended evening hours surgeries were not offered. Patients were able to book appointments at both surgeries either by telephone or online. Pre-bookable appointments could be booked up to one year in advance and urgent appointments were available on the same day for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was better than local and national averages in most areas. People told that they were able to get appointments when they needed them and that urgent appointments were always available on the day.

- 90% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 75%.
- 93% patients said they could get through easily to the surgery by phone (CCG average 75%, national average 73%).
- 98% patients described their experience of making an appointment as good (CCG average 74%, national average 73%).

However, waiting times were similar to local and national averages and comment cards told us that patients sometimes had to wait longer than 15 minutes to be seen.

- 66% patients said they usually waited 15 minutes or less after their appointment time (CCG average 69%, national average 65%).

Are services responsive to people's needs?

(for example, to feedback?)

- 66% patients felt they don't normally have to wait too long to be seen (CCG average 62%, national average 58%)

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints which was in line with recognised guidance and contractual obligations for GPs in England.

The practice manager was the designated responsible person who handled all complaints in the practice. We saw that complaints were recorded and acted upon although it was not always clear within the record keeping what lessons were learned and shared.

We looked at available details of seven complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. There was openness and transparency with dealing with the complaint and an apology was given to the complainant where required. There were no recurring themes, although

we did not see evidence of consistent records to show that lessons had been learned and shared. However, the practice told us that lessons had been learnt from concerns and complaints and action had been taken as a result to improve the quality of care. For example, where the wrong patient was contacted to discuss test results that he had not had, the practice investigated and found that three points of reference had not been adequately checked when selecting the patient record. The patient was given an apology and refresher training was provided for all staff on Information Governance. (Information Governance is all about ensuring that information is adequately protected, securely stored and shared appropriately) so that staff had a better understanding of the need to adhere to identification processes and the impact of not doing this.

We saw that information was available to help patients understand the complaints system. For example there was a notice in the reception area telling patients how to complain

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients and all staff appeared motivated in putting the patient first in every situation. Staff felt involved in day to day practice issues even though they did not have a clear vision of future plans or strategy for development and change.

The partners had ideas on developing the practice to accommodate the likelihood of a rise in patient numbers within the next two years and had discussed succession planning for the immediate future and to plan for future retirement of the partners, but this had not been shared with staff at the time of our visit.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of policies, processes and good quality care. This ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff through the practice's computer system
- Those staff who attended regular meetings had an understanding of the performance of the practice and issues discussed.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements and we saw examples of how audit was used to implement improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, learning from significant events and complaints was not consistently recorded or widely shared.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality

care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and took time to listen to them when needed.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had a process in place for knowing about notifiable safety incidents which was managed by the practice manager. Staff we spoke to told us that they knew what to do when they were alerted to a safety incident and that they were encouraged to report and record any significant events that occurred within their daily practice. There was a process for them to do this.

When unexpected safety incidents occurred, the practice gave affected people truthful information and a verbal and written apology where one was required. They kept written records of complaints and significant events. Staff we spoke to who regularly attended practice meetings were aware of significant event analysis, however, some staff were not aware and in particular, staff groups who were not involved in a significant event were not aware of any themes or learning.

There was a clear leadership structure in place and staff felt supported by management. Staff told us that the practice held regular team meetings which were held in teams apart from the practice meeting where there was representation from every team except the administration and reception team. The care coordinator meeting included all relevant community team and a GP partner. There was also opportunity to attend quarterly meetings where development was the focus.

Staff told us that there was an open culture within the practice would raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team away days were held every 3 months for non-clinical staff and once a year for clinical staff.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met

Are services well-led?

Good 

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

on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, The PPG were involved in the plans for improving the reception area.