

# Crich 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 Crich Medical Practice on 23 August 2016 Overall the practice is rated as good.

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

- The practice had systems in place to enable staff to effectively report and record significant events. Learning from significant events was reviewed monthly and shared internally and externally.
- Risks to patients and staff were assessed and managed. However, the practice were in the process of confirming hepatitis B immunisation status for some staff as their immunisation record had not been kept up to date in the preceding year.
- Staff delivered care and treatment in line with evidence based guidance and local guidelines. Training had been provided for staff to ensure they had the skills and knowledge required to deliver effective care and treatment for patients.
- Feedback from patients was that they were treated with kindness, dignity and respect and were involved in decisions about their care.
- Information about services and how to complain was available and easy to understand. Complaints were dealt with promptly and the practice demonstrated they were keen to meet with complainants to ensure issues were resolved as quickly as possible.
- Patients said they generally found it easy to make an appointment even though the practice did not offer evening appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Adjustments had been made to the premises to ensure these were suitable for patients with a disability. However, the branch surgeries were in need of updating and this was being planned.
- There was a clear leadership structure which all staff were aware of. Staff told us they felt supported by the lead GP and the practice manager. The practice proactively sought feedback from staff and patients, and we heard about examples where the practice had acted on suggestions for improvement.

# Summary of findings

- The practice worked closely with their patient participation group (PPG) to identify areas for improvement. The practice was responsive to suggestions from their PPG and was working with them to increase patient engagement in the online services.

The areas where the provider should make improvement are:

- To strengthen some risk assessments to ensure that risks to staff and patients are mitigated whilst new practices are being embedded.

- To strengthen recording of staff immunisation status, staff training, and DBS checks.
- To formalise infection control audits and action plans and review progress regularly to ensure that recommendations made are completed. Ensure that planned refurbishment of branch practices meets with infection control standards.

**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. Lessons were shared to make sure action was taken to improve safety in the practice and these were reviewed six monthly.
- When things went wrong patients received support, information, and a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. All staff knew how to raise a safeguarding concern.
- Risks to patients were assessed and well managed.
- There were systems in place to manage safety alerts, including medicines alerts which were acted upon. The practice had identified that actions taken were recorded on an individual basis but there was no central oversight of this. They had taken action to rectify this and we saw that a central record had been implemented and actions taken for the preceding four alerts had been recorded.
- There was a good process for managing incoming mail including test results which were acted upon on the same day if required.
- There were enough staff to keep people safe.

Good



### Are services effective?

The practice is rated as good for providing effective services.

Our findings showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines, and clinicians used these as part of their work.

- Audits and reviews were undertaken and improvements were made to enhance patient care.
- Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

Good



# Summary of findings

- Close working with multi-disciplinary teams to support patients at risk of unplanned hospital admission had resulted in an admission rate that was lower than CCG and national averages.
- There was evidence of appraisals and personal development plans for most staff. However, we found that appraisals for 75% of non clinical staff had been delayed for up to two months and were scheduled for September and October.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.

## Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice highly for several aspects of care. For example; 95% of patients described the overall experience of this GP practice as good compared to the CCG average of 87% and the national average of 85%.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Practice staff told us that patients were their highest priority and gave examples of how they would go the extra mile where possible. For example; GPs would sometimes collect medicines and deliver them to patients who were housebound.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Attached community staff told us that the GPs were very caring towards their patients.
- The practice kept a register of patients who were carers and provided a carers notice board signposting carers to where they could find support. A monthly carers clinic and annual health checks were also available.
- Social events were planned for staff who also told us that they felt cared for by the GPs.

Good



## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



# Summary of findings

- Patients said they found it easy to make an appointment with their usual GP and there was continuity of care, with urgent appointments available the same day. Patients had a named GP who was responsible for their overall care, and were encouraged to utilise their 'usual' GP.
- The main practice had good facilities and was well equipped to treat patients and meet their needs. There were two branch practices attached which enabled patients ease of access in the rural area. The branch practices were able to dispense medicines to eligible patients and there was a delivery service available.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- They had achieved 97% of the total QOF points available to them with an exception reporting rate of 9% which was 2% lower than the CCG average and the same as the national average.

## Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- The practice manager had been recently recruited and was working with the partners to make positive changes to some systems and processes. The practice were aware that improvements were required in relation to record keeping of some activities and were working on a plan to address this. For example; central records of staff immunity status, records of some face to face mandatory training that was not included within their e-learning database, and recording of actions taken following safety alerts.
- 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 held regular practice meetings. These included the community support team where required and meeting minutes were made available on the practices computer system.

Good



# Summary of findings

- There was a governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. GPs had a lead role in an aspect of management which contributed to the governance agenda.
- The partners encouraged a culture of openness and honesty.
- There were systems in place for notifiable safety incidents that ensured relevant information was shared with staff to ensure appropriate action was taken. A system to record actions taken had been recently implemented.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

# 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.

The practice offered proactive, personalised care to meet the needs of the older people in its population. For example;

- They utilised the services of a care co-ordinator to facilitate multi disciplinary meetings with a GP, district nurse, community matron, social services and mental health team to discuss and plan care for vulnerable elderly patients so that referrals could be made to access the most appropriate care quickly. Referrals included the social care team, community physiotherapy, occupational therapy service and falls team.
- The practice had two branch surgeries, predominantly to serve local communities where public transport is limited
- They offered home visits to housebound patients for urgent visits and routine visits, including biannual visits for medication reviews
- The practice provided regular Care Home patient reviews by their usual doctor in addition to urgent visits as needed. They also visited the care home on a monthly basis to conduct a ward round whereby patients ongoing care was discussed, medicines reviewed and discussions with relatives as required.
- They provided a medicines delivery service from their dispensaries to patients unable to collect their own medicines. For those patients who were not eligible for this service but were housebound, very sick or vulnerable, a GP would deliver these to them personally in exceptional circumstances.
- In addition to regular medication reviews, they performed DRUMS (Dispensing Review of Use of Medications) as part of a quality assurance scheme for our dispensing patients over the age or 65 and on three or more medications
- They had engaged with the Unplanned Admissions DES and maintained care plans for 2% of patients with multiple health problems or with frequent admissions, including all local care home residents
- They offered a monthly carers clinic to provide support to identified carers
- They encouraged patients to engage with local groups including a walking club and weekly lunch club.
- They hosted an on-site hearing clinic provided by a local company fortnightly.

Good





# Summary of findings

## People with long term conditions

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

Good



- Nursing staff had roles in chronic disease management who worked with patients' named GP to provide a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice had achieved 91% of QOF points for diabetes related indicators, which was 2% below the CCG average and 1% above the national average. Exception reporting at 12% was 1% lower than the CCG average and 2% lower than the national average.
- The practice had recognised that improvements could be made to diabetes care, and had provided additional training for one of the practice nurses. The practice had since been able to provide joint clinics with as visiting diabetic nurse, and a pre-diabetes clinic to advise patients who may be at risk of developing diabetes.
- The practice recognised that leg ulcers were taking a considerable amount of nursing time, and employed a practice nurse who was a nurse on a Burns Ward bringing useful experience to the team.
- The practice offered a 24 hour BP monitoring service for the management of hypertension
- They provided DMARD monitoring as part of the Shared Care scheme for patients with rheumatoid arthritis.
- They provided anticoagulation (Warfarin) service within the practice and in patients own home for patients who were housebound.
- The practice had a Carers Co-ordinator who provided written information and advice to patients identified as Carers and monthly carers clinics where they could obtain advice and support

## Families, children and young people

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

Good



- 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.

# Summary of findings

- The practice had a dedicated child safeguarding lead and staff were aware of who this was.
- Staff had received training in child safeguarding at a level relevant to their role
- Immunisation rates at 98-100% were higher than both CCG and national averages for all standard childhood immunisations. There was a dedicated member of staff who followed up non-attenders to ensure they received another appointment that was convenient to them.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Same day appointments were available for children where a parent or carer felt there was an urgent need.
- The practice worked closely with an on-site midwife and health visitor who told us that they had a positive relationship with the practice.
- They provided 6 week mother and baby checks and a contraceptive advice, IUD (coil) fitting and implant service with a female GP with expertise in this area.

## **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 was proactive in offering online services for booking appointments and requesting prescriptions
- They had recruited an additional health care assistant (HCA) and provided training to support the provision of NHS health checks for patients.
- They provided an on-site phlebotomy service and contributed financially towards a phlebotomy service at the local hospital which offered early opening times from 7.30am each weekday morning for ease of access.
- They provided telephone appointments and call backs when requested during the day.
- They hosted an on-site Citizens Advice clinic monthly
- They provided a travel clinic including Yellow Fever vaccination

Good



# Summary of findings

## 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 those with a learning disability and those who were housebound or isolated.
- The practice offered longer appointments for patients with a learning disability and 60 minute health checks.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients and utilised the services of a care coordinator to facilitate care and referrals to community services and support, including 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.
- The practice held monthly safeguarding meetings attended by GPs, Macmillan Nurse, Health Visitor, and District Nurses

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).

- A total of 88% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was the same as the CCG and national averages.
- The practice offered an annual health check for patients with a serious mental health condition. A total of 93% of patients with a serious mental health condition had a comprehensive care plan documented in their record in the preceding year. This was 1% above the CCG average and 5% above the national average. Exception reporting at 26% was 5% higher than the CCG average and 13% higher than the national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Good



# Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. The practice maintained strong links with their local Care Home where a majority of patients have a dementia related illness, and involved the local Older Adults mental health team and Dementia team where required.
- The practice had recently collaborated with other local practices to obtain funding for a Community Psychiatric Nurse who will provide regular in house clinics soon.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing better than local and national averages. There were 216 survey forms distributed and 133 were returned. This represented a 62% response rate.

- 92% of patients found it easy to get through to this practice by phone compared to the CCG average of 74% and the national average of 73%.
- 85% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 75% and the national average of 76%.
- 95% of patients described the overall experience of this GP practice as good compared to the CCG average of 87% and the national average of 85%.

- 91% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 82% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 12 comment cards which were all positive about the standard of care received. Patients told us that the practice provided a quality service and that staff were professional and approachable.

We spoke with three patients from the main surgery during the inspection. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

## Areas for improvement

### Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- To strengthen some risk assessments to ensure that risks to staff and patients are mitigated whilst new practices are being embedded.
- To strengthen recording of staff immunisation status, staff training, and DBS checks.
- To formalise infection control audits and action plans and review progress regularly to ensure that recommendations made are completed. Ensure that planned refurbishment of branch practices meets with infection control standards.

# Crich 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 adviser, and an Expert by Experience.

### Background to Crich Medical Practice

Crich Medical Practice provides general medical services to approximately 7,240 patients, and is run by a partnership of five GPs (three male and two female) which has been a stable partnership for more than five years.

As the practice is a training practice, GP Registrars work at the practice throughout the year. (GP Registrars are fully qualified doctors who are receiving additional training to work as a GP)

There are currently two Registrars working at the practice. (both are male)

The main practice is in Crich with a branch surgery at Holloway and one at South Wingfield. Patients can attend either the main practice or one of the branch practices.

We visited one of the branch surgeries to speak with some staff as part of this inspection but did not make a full inspection of the premises at either of the branch surgeries.

The practice team includes administrative staff, a Lead nurse, two practice nurses, two health care assistants and a team of dispensers.

The practice holds the General Medical Services (GMS) contract to deliver essential primary care services. The

practice is open between 8am and 6.30pm Monday to Friday with telephone lines open from 8.30am to 6pm. Appointments at all practices are generally available from 8.30am to 11.30am and 3.30pm to 6pm daily.

The practice does not provide out-of-hours services to the patients registered there. During the evenings and at weekends an out-of-hours service is provided by Derbyshire Health United. Contact is via the NHS 111 telephone number.

### Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 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 we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 23 August 2016. During our visit we:

- Spoke with a range of staff (GPs, practice manager, practice nurses, care coordinator, dispenser, community staff, reception and administration staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members

# Detailed findings

- Reviewed an anonymised sample of 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 were provided for specific groups of people and what good care looked 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. There had been 40 events recorded in the preceding 12 months. A summary of the past 12 months demonstrated learning was shared, and when appropriate changes were made to protocols and practice.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available which was completed manually. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. For example; when a patient's repeat prescription request was found attached to another patient's request, the practice informed the patient about their breach in confidentiality and apologised.
- The practice conducted monthly meetings to discuss significant events and each one was reviewed six months after the event to check whether learning had been imbedded. In addition, an annual meeting was held to look at trends.

The practice had a process to review and cascade medicines alerts received via the Medicines and Healthcare Regulatory products Agency (MHRA). When this raised concerns about specific medicines, searches were undertaken by the GPs in conjunction with the CCG pharmacist to check individual patients and ensure effective action were taken to ensure they were safe. For example, prescribing an alternative medicine if a concern had been raised about the safety of a particular medicine.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems and processes in place to keep patients safe. For example:

- The practice had suitable arrangements to safeguard children and vulnerable adults from abuse which reflected relevant legislation and local requirements. The GP was the safeguarding lead and had undertaken level three training for child safeguarding. Staff demonstrated they understood their responsibilities to safeguard patients and all had received training relevant to their role including domestic violence. Records reviewed showed quarterly safeguarding meetings took place where the GP, practice nurse, and health visitor discussed patients in vulnerable circumstances including children. A system was in place for highlighting vulnerable patients on the practice's computer system to ensure staff were aware of any relevant issues when patients attended appointments.
- Information telling patients that they could ask for a chaperone was visible in the reception area and consultation rooms. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. 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. The practice had trained all receptionists in the chaperoning role but four had not yet completed a DBS check. A risk assessment had been made and those receptionists were not acting in the chaperone role until the checks had been completed
- The main practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. However, the practice told us that the branch surgeries were in need of some attention in regard to cleaning schedules, decoration and replacement of worn items. The practice had a Lead Nurse as the nominated infection control lead who was able to liaise with the CCG infection control lead. There was an infection control policy in place and staff had received infection control training, for example, training in handwashing and specimen handling. We saw that an audit had been carried out in the preceding two weeks in conjunction with the CCG infection control lead. The audit identified a number of issues at both branch surgeries. This included some stock that was found to be out of date, which was immediately removed by the practice. Other issues included further attention to cleaning, including some carpets, toys, footstool and fans, and a cleaning schedule implemented for each room so that this could be recorded accordingly. It was



## Are services safe?

also recommended that tiles in some toilets and some equipment needed to be replaced. On the day we visited, the practice were aware of these recommendations and were in the process of drawing up a formal plan to address all of the concerns. They had already addressed many of them with immediate effect. On the day we visited, the main practice was clean and well managed and all the stock and medicines we looked at were in date. We were assured by the CCG infection control lead as well as the practice that the most urgent issues had been addressed and there was a longer term plan to address those remaining.

- There were good arrangements in place for managing incoming mail including test results. These were checked daily by GPs, and where a test result showed an abnormal result, a GP would contact the patient on the same day to discuss or make an appointment for them. Where a GP was sick or on holiday, another GP would check and action those results
- There were systems in place to ensure results were received for all samples sent for the cervical screening programme. There was a dedicated administrator who followed up on samples sent to ensure that no results were missed. Any abnormal results were dealt with on the day by GPs.
- Arrangements for managing medicines ensured that patients were kept safe. For example, there was a GP who was the lead for medicines management and worked with the clinical commissioning group (CCG) pharmacist to monitor adherence to protocols relating to prescribing and dispensing. Regular medicines reviews were conducted and actions recommended by the CCG pharmacist were followed up by GPs. The CCG pharmacist also conducted regular searches on medicines and identified patients to GP for medicines reviews. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. We saw evidence to show that patients on high risk medicines were appropriately reviewed. There was a temperature monitoring system in the medicines fridges to ensure that vaccines were stored at the correct temperature, and emergency drugs were in date, and regularly checked.
- There was a named GP responsible for the two dispensaries and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and

development. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). Some of these had been recently reviewed and updated.

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- Blank prescription pads and paper were stored securely and processes were in place to monitor their use which included recording serial numbers.
- Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) were being used by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed five personnel files and found 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.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- The practice had procedures in place to monitor and manage risks to patients and staff safety. There was a health and safety policy available which was accessible to all staff electronically.
- Newly recruited staff were offered a hepatitis B vaccination as part of their induction. The practice had identified that their records of staff immunisation status were not up to date, and during the preceding month had put an action plan in place to address this. The plan included establishing the immunisation status of all staff, provision of vaccinations/immunisations where required, and creation of a new up to date immunisation status register. There was a risk assessment in place to support action for staff who were unsure whether they were up to date, or where their status was not recorded on the register.

## Are services safe?

- Fire alarms were tested weekly and records kept, and staff told us they knew what to do in the event of a fire. A fire drill exercise had been carried out recently.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw a record of this.
- The practice had processes in place to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a bacterium which can contaminate water systems in buildings). There had been a recent risk assessment and water test for Legionella and an action plan was being implemented eg; a hot water tap had been replaced.
- Arrangements were in place to plan and monitor staffing levels needed to meet patients' needs. There was a system in place for different staffing groups to ensure that enough staff were on duty. Each staffing group had agreements about the number of staff who could be on leave at the same time to ensure service provision was not adversely affected. GPs would cover other GP's annual leave, and two regular locum GPs were utilised where required.

### **Arrangements to deal with emergencies and major incidents**

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was a panic alarm system in all the consultation and treatment rooms which alerted staff to any emergency.
- Basic life support training was delivered annually and there were emergency equipment available which we found to be in date.
- There was a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were kept in a secure area of the practice and all staff knew of their location. The medicines we checked were in date.
- The practice had a comprehensive business continuity plan in place. This covered major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and a paper copy was available at each site.

# 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. They monitored these guidelines through risk assessments, audits and random sample checks of patient records. The practice had systems in place to ensure all clinical staff were kept up to date through regular meetings, training updates and mentorship.

The practice worked with the CCG pharmacist to provide medicines reviews for patients which had resulted in their prescribing practice to be in line with national prescribing guidelines and had exceeded the targets set by the CCG. The practice had 32% of patients who were eligible to receive their medicines from the practices dispensaries, however, the practice had managed to make a saving of £112.5K in the preceeding year by working closely with the CCG pharmacist and adhering to prescribing protocols.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available. This was the same as the CCG average and 2% better than the national average. The clinical exception rate was 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This was 2% better than the CCG average and the same as the national average for exception reporting.

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 91% was similar to the CCG average of 93% and better than the national average which was 89%. The exception reporting was similar to both CCG and National averages.

- Performance for mental health related indicators at 99% was better than the CCG average of 97% and better than the the national average which was 93%. However, their exception reporting at 23% was higher than both the CCG and national averages which were 17% and 11% respectively.

- Performance for asthma related indicators at 100% was higher than the CCG average of 99% and the national average of 97%. The exception rate for these indicators was 4% higher than the CCG average and 7% higher than the National average.

There was evidence of quality improvement including clinical audit. There had been 12 clinical audits completed in the last two years, most of which were selected by GPs according to their developments needs or as a result of an issue identified by the practice. We looked at two 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 improvement to monitoring patients taking Terbinafine (a medicine used to treat fungal nail or skin infections)

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We looked at the records for recently recruited staff and found that an induction checklist had been completed. A comprehensive induction programme was in use for GPs including Registrars.
- There was an appraisal system in operation at the practice and clinical staff had received their appraisal in the preceding 12 months. However, appraisals had been delayed by one to two months for 75% of non clinical staff. These were scheduled for September and October. We were told that the delay was due to recruiting a new practice manager who was required to prioritise other aspects of managing the practice. For example; reviewing processes and systems. Clinical staff we spoke with told us that they had received an appraisal that included a development plan in the preceeding year and that the practice were very keen to support

# Are services effective?

## (for example, treatment is effective)

development and training, including external training which was funded by the practice. Nurses were also given time and support to address their needs for nurse revalidation.

- Staff were supported to undertake training to meet personal learning needs to develop their roles and enhance the scope of their work. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. Development for non-clinical staff included training in additional roles in order to broaden the skill mix of the team.

### 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 and the computer system. This included care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together 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, when they were referred, or after they are discharged from hospital.

The care coordinator was able to arrange for patients to access help and assistance with a range of support programmes through referral to The Live Life Better Derbyshire programme. This included; exercise programmes, weight management programmes, advice about debt and housing, and smoking cessation support sessions. We saw evidence that multi-disciplinary team meetings took place on a monthly basis incorporating reviews of patients at risk of hospital admission, end of life patients, and those who had complex needs. These meetings included a GP, care coordinator, community health team representatives, (community matron, district nurse, health visitor), social work team and the community mental health team where required. Care plans were routinely reviewed and updated and risks assessed.

### Consent to care and treatment

Staff understood and sought patients' consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005.

When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance, and where a patient's mental capacity was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment. Staff recorded consent to treatment and procedures in the patient's record.

Staff sought patients' consent to care and treatment in line with legislation and guidance.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet or smoking cessation. Patients were then signposted to the relevant service.

The practice's uptake for the cervical screening programme was 85% which was higher than the CCG average of 83% and the national average of 81%. Exception reporting for this indicator at 2% was lower than both the CCG and national averages. The practice contacted patients who did not attend for their cervical screening test to remind them that they had missed their appointment and advise them to make a new one

The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

Patients who were eligible for the bowel screening programme were actively encouraged to attend which resulted in a total of 68% of eligible patients who had attended for bowel screening compared with the CCG average of 61% and the national average of 58%.

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 96% to 100% which was higher than the CCG average of 94% to 98% and five year olds from 97% to 100% which was also higher than the the CCG average of 91% to 98%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

## Are services effective? (for example, treatment is effective)

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice had recently run a campaign to improve health awareness and increase cardiovascular screening. They had recruited and trained a HCA to provide screening and we were told that there appeared to be an increased uptake, although it was too soon to audit the results of this.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with 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; 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.
- Patients and staff told us that the GP partners frequently went that extra mile to help people who need it.

All of the patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They also told us that they had an excellent relationship with the practice and found the staff to be respectful, kind and caring.

Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. We were told that GPs sometimes collected prescriptions for patients who were housebound or vulnerable and delivered these to them in exceptional circumstances.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.

- 95% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 90% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 92% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:



## Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- Patients with a chronic illness were encouraged to contribute to their care plan and to bring it to each appointment.
- The practice utilised a care plan that was shared with the GP out of hours service and also a Derbyshire Health and Social Care Plan to enable comprehensive sharing of information for patients who were at risk of unplanned admission to hospital.

### **Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. The practice also hosted The Citizens advice Bureau regularly.

The care coordinator was able to direct patients to a wide variety of organisations to support people who needed help. This included referral to the Live Life Better Derbyshire programme, bereavement services, and self help groups.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 110 patients as carers which was around 1.5% of the practice list. The practice had appointed a dedicated carers lead who was able to direct carers to various avenues for support. The practice offered an annual health check for carers and hosted a monthly carers clinic run by The Derbyshire Carers association. Written information was also available in the waiting area.

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

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice served a population that was 10% higher than the CCG and national averages for people aged over 65 and the number of people with a long term condition was 7% higher. They had configured their services to meet the needs of their population. For example;

- They provided a dispensing service at the two branch practices and dispensed to 32% of the patient list.
- They had a good relationship with the care home aligned with them and made monthly ward rounds as well as ensuring that patients' regular GP visited when required.
- Home visits were available when required.
- Cardiovascular screening was encouraged and a new nurse was recruited to provide this service.
- A pre-diabetes audit was conducted and as a result, a pre-diabetes clinic was set up to advise patients who were at risk of developing diabetes.
- A specialist nurse was recruited to work with patients with leg ulcers to improve outcomes for this problem.
- They worked closely with a care coordinator and the multi disciplinary team to assess needs and plan care for older people to avoid unplanned admissions to hospital. This had resulted in the number of unplanned admissions being below the CCG and national averages.

In addition the practice provided the following;

- They had worked in collaboration with the CCG and their local hospital to implement a 'clinician connect' scheme to enable GPs to get advice from a consultant. This helped to avoid unnecessary admissions.
- There were longer appointments available for patients with a learning disability.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately
- There were disabled facilities, a hearing loop and translation services available.

### Access to the service

The practice was open between 8am and 6.30pm Monday to Friday with telephone lines open from 8.30am to 6pm. Appointments at all practices were generally available from 8.30am to 11.30am and 3.30pm to 6pm daily. Extended hours appointments were not offered, however, patients told us that they could usually get an appointment when they needed one.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were always 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 comparable to local and national averages.

- 83% of patients were satisfied with the practice's opening hours compared to the CCG average of 81% and the national average of 78%.
- 92% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits and we were told that these were rarely refused.

### Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. This was on their website and on a poster in the waiting area.

We looked at 10 written complaints received in the last 12 months and found that these were satisfactorily handled, dealt with in a timely way, and the practice were open and transparent. Lessons were learnt from individual concerns



## Are services responsive to people's needs? (for example, to feedback?)

and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For

example, after receiving a complaint about the telephone system, the practice discussed this at their practice meeting and are looking at how they can implement a more suitable system.

# Are services well-led?

Good 

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

## Our findings

The practice had emerged through a period of change whereby a number of new key members of staff had been recently recruited and were settling into their new roles. This included the practice manager who had no previous NHS experience but who brought many key management skills to the practice. The practice had prioritised a review and updating of policies, systems and processes and the practice manager had liaised with the CCG and made improvements to some of these in a short time.

### Vision and strategy

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

- The practice ethos included providing a high standard of medical care to the whole population and to create a partnership between patients and healthcare professional.
- The practice's aims and objectives were detailed within the practice's statement of purpose.
- Staff we spoke with demonstrated awareness of the practice vision and values, and knew what their responsibilities were in relation to these.
- The practice had a supporting business plan which reflected the vision and values, and planned to increase staff capacity in the future by enabling some non clinical staff to train in an additional role.

### Governance arrangements

The practice had effective governance systems in place which supported the delivery of good quality care. These outlined the structures and procedures in place within the practice and ensured that:

- The practice had a clear staffing structure and staff were aware of their roles and responsibilities. Lead roles were divided between GPs and nurses.
- A wide range of practice specific policies and protocols were in place to support staff. We saw that policies and protocols were being reviewed and were in the process of being updated by the newly recruited practice manager in conjunction with clinicians.

- There was a comprehensive understanding of the performance of the practice. This ranged from performance in respect of access to appointments, patient satisfaction and clinical performance. Staff were proud of the practice's achievements and performance.
- Arrangements were in place to identify, record and manage risks and ensure mitigating actions were implemented. The practice manager had recently conducted a number of risk assessments to ensure that staff and patients were kept safe whilst these were being amended and updated to reflect current or new agreed practices.
- The practice had identified that improvements were required with regards to record keeping and had implemented improved systems; For example to maintain an up to date record of staff immunisation and DBS checks, face to face training (not already captured on the computer system), and to record actions taken following a safety alert. These improvements had been recently made and were expected to be fully embedded into practice soon.

### Leadership and culture

The partners within the practice had a range of experience and demonstrated they had the capacity to run the practice to ensure high quality care. For example, we saw that GPs had special interests and additional qualifications in a range of areas. For example in contraception and sexual health, and training for Registrars. The partners and the practice manager were visible within the practice and staff told us they were approachable and listened to all members of the practice staff team.

The practice staff told us they worked well as a team and attended social events occasionally; this helped people build effective working relationships and developed the open culture in the practice.

When there were unexpected or unintended safety incidents the practice offered affected people support, provided explanations and verbal or written apologies where appropriate.

We saw that there was a clear leadership structure in place and staff felt supported by management. Staff told us about examples where GPs had gone the extra mile to support a member of staff who needed additional

# Are services well-led?

Good 

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

emotional support during a time of individual crisis. Staff also told us that they could talk to any member of the management team if they needed to raise a concern and that there was an open culture within the practice.

Feedback from staff told us they felt valued and supported by the partners and the management within the practice and that they were encouraged to identify opportunities for improvements to the delivery of service.

Staff told us they had the opportunity to raise issues at regular team meetings.

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

We saw that the practice was open to feedback and encouraged feedback from patients, the public and its staff. The practice ensured it proactively sought the engagement of patients in how services were delivered:

- The practice gathered feedback from patients through the active patient participation group (PPG) who met four times each year. They carried out patient surveys and discussed proposals for improvements to the practice management team. For example: the practice manager worked with the PPG to demonstrate how to use the online appointments system so that PPG members could assist patients with this.
- Changes had been made to how the dispensaries worked so that this service could be kept at both branch surgeries

· Improvements were made to the telephone system at the main surgery.

· The practice had implemented a 'usual doctor' list to improve continuity of care. This was in addition to the NHS named doctor scheme.

· The practice gathered feedback from staff through meetings, appraisals and ongoing discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

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.

## **Continuous improvement**

There was a focus on listening to patients and putting the patient at the heart of everything. This is demonstrated by the patient survey results which are much higher than CCG and national averages.

As well as the usual arrangement of formal meetings, the partners held monthly clinical reflection meetings for all clinical staff to enable staff to reflect on clinical practice and for learning to be shared.