Goyt Valley Medical & Dental 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	**Outstanding** ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Good** ●
Are services responsive to people's needs?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Goyt Valley Medical Practice on 20 September 2016. Overall, the practice is rated as outstanding.

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

- Patients overwhelmingly told us they received excellent care and were treated with compassion, dignity and respect. They also said they were involved in their care and decisions about their treatment. This was corroborated bythe outcomes of the latest national GP patient survey, friends and family test results, and CQC comment cards.
- There was an effective system in place for the reporting and recording of significant events. Learning was applied from events to enhance the delivery of safe care to patients.
- Clinicians kept themselves updated on new and revised guidance and discussed this at clinical meetings. Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Feedback from patients we spoke with on the day, and from CQC comment cards, demonstrated that people had excellent access to GP appointments.
- We saw evidence of an active programme of clinical audit that reviewed care and ensured actions were implemented to enhance outcomes for patients.
- The practice planned and co-ordinated patient care with the wider health and social care multi-disciplinary team to deliver effective and responsive care and keep vulnerable patients safe. Regular meetings took place to discuss and review patients' needs.
- The practice had an appraisal system in place and supported staff training and development. The practice team had the skills, knowledge and experience to deliver high quality care and treatment.
- Longer appointments were available for those patients with more complex needs, and there was greater flexibility in offering appointments for vulnerable patients such as those with a learning disability.
- The practice had good facilities and was well-equipped to treat patients and meet their needs. The premises were accessible for patients with impaired mobility.
- There was a clear leadership structure in place and the practice had a governance framework which

Summary of findings

supported the delivery of good quality care. Regular practice meetings occurred, and staff said they felt valued and that GPs and managers were approachable and always had time to talk with them.
- The partnership had a clear vision for the future of the service, and were engaged with their Clinical Commissioning Group (CCG) in order to progress this.
- The practice had an open and transparent approach when dealing with complaints. Information about how to complain was available, and improvements were made to the quality of care as a result of any complaints received.
- The practice patient participation group (PPG) was active and helped to champion the patient voice to influence developments within the practice.

We saw the following areas of outstanding practice:

- The nurse practitioners provided on-the-day assessment and care for patients presenting with new and acute conditions, and minor illnesses. They undertook home visits and one provided regular input at a local care home for patients with dementia. This alleviated pressure on GPs allowing them more time for complex consultations and produced positive outcomes for patients. For example, input to the care home demonstrated effectiveness through the reduction in contacts with the out of hours' service and hospital admissions. Over a 12 month period, hospital admissions fell from 67 to 43, and contact with the out of hours' service reduced from 23 to 17 patients. There was also a decrease in falls at the home from 56 between January to March 2014, to 24 in the corresponding period the following year.
- The practice directly employed a mental health support worker. Data for emergency admissions for mental health over a three year period showed low figures for the practice. These were the lowest within their locality and one of the lowest within their CCG. The practice were able to provide evidence that over the last two years, only four of 22 patients at high risk of hospitalisation had been admitted, with two of the admissions being outside of the practice's direct control.
- The practice demonstrated a responsive approach by taking account of the needs of their local population, and not just their registered patients. This enabled services to be delivered closer to patient's homes.

The areas where the provider should make improvement are:

- Review the need to take emergency medicines on home visits, or consider a risk assessment to be completed for this.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Staff were supported to report significant events in a supportive environment. Learning was applied from incidents to improve safety in the practice.
- The practice had effective systems in place to ensure they safeguarded vulnerable children and adults from abuse.
- The practice worked to written recruitment procedures to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- There were systems in place to manage medicines on site appropriately.
- Patients on high-risk medicines were monitored on a regular basis.
- Actions were taken to review any medicines alerts received by the practice, to ensure patients were kept safe.
- The practice had systems in place to deal with medical emergencies within the surgery. However, emergency medicines were not taken on home visits and there was no risk assessment in place to cover this.
- Risks to patients and the public were well managed. The practice received support for health and safety matters from an external contractor, and there was a comprehensive and proactive approach to risk assessment.
- The practice had developed contingency planning arrangements supported by an up to date written plan that was regularly updated.

Are services effective?

Outstanding

- The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The practice had acquired a total achievement of 99.1% for the Quality and Outcomes Framework (QOF) 2014-15. This was slightly above the CCG average of 98.1%, and above the national average of 94.7%.
- Regular clinical meetings took place to discuss issues such as new guidance. Learning lunches provided an environment of ongoing learning and clinical staff development within the practice.

Summary of findings

- The practice had proactively reviewed their skill mix to meet the demands of patients and access to care. This included directly appointing two nurse practitioners whose roles had been developed to provide first-contact patient care and home visits. The practice employed a mental health support worker, and had recently joined a pilot scheme to place a prescribing community pharmacist within the practice team. We saw examples of how all of these roles had impacted positively upon patient care and outcomes.
- The practice maintained comprehensive documentation to demonstrate their compliance with standards. For example, minutes from meetings were clear and concise and provided a source of reference for other staff to review outcomes from the discussions held.
- The practice worked collaboratively with the wider health and social community to plan and co-ordinate care to meet their patients' needs at regular multi-disciplinary team meetings.
- Staff had the skills and experience to deliver effective care and treatment. New employees received inductions, and all members of the practice team had received an appraisal in the last year, which included a review of their training needs.
- We saw examples of how clinical audit was being used to drive quality and enhance safe patient care and treatment.

Are services caring?

Good

- We observed a patient-centred culture and approach within the practice. Staff treated patients respectfully and with kindness.
- Data from the latest GP survey in July 2016 showed that patients rated the practice higher than local and national averages in respect of the care they received.
- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated that they felt treated with compassion and dignity, and were given sufficient time during consultations. Patients said they were involved in decisions about their care and treatment.
- Feedback received from managers at the care home and the community nursing team was very positive about the high standards of care provided by the practice team.
- The practice was in the process of reviewing their carers register for accuracy. Following this, they intended to review their support for carers, such as the provision of an annual health review. Information was available on the various types of support available to carers.

Summary of findings

- As a small semi-rural practice, the team knew their patients very well. This aided them in providing personalised care and ensured greater continuity for patients.
- We were provided with examples of individual patient stories which reflected the caring approach of the practice team. This included a patient who had been supported to die an appropriate and dignified death within a care home, rather than being admitted into the hospital.

Are services responsive to people's needs?

Outstanding

- Comment cards and patients we spoke with during the inspection provided mainly positive experiences regarding obtaining an appointment with a GP. The latest GP survey showed that patient satisfaction was above local and national averages with regards access to GP appointments.
- The practice had developed the nurse practitioner role to enable them to see patients as the primary contact for any new condition or minor illness. The nurse practitioners operated a triage system when all the appointments had been booked for the day, and would advise patients or arrange to see them either in the surgery or at home. This created good patient access and provided capacity for GPs to see patients with more complex needs.
- Patients could book appointments and order repeat prescriptions on line. The practice participated in the electronic prescription scheme, so that patients could collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- The practice hosted some services on site including counselling and a weekly clinic provided by the midwife. This made it easier for their patients to access services locally.
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The premises were tidy and clean and well-equipped to treat patients and meet their needs. The practice accommodated the needs of patients with disabilities, including access to the building through automatic doors.
- The practice reviewed any complaints they received and dealt with these in a sensitive and timely manner. Information about how to make a complaint was available for patients. Learning from complaints was used to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they could be offered a more private area to ensure their privacy.

Summary of findings

Are services well-led?

Outstanding ☆

- The partners were committed and passionate to delivering high quality care and promoting good outcomes for their patients.
- The partners and management closely reviewed the service and strove to adapt to new demands to best meet their patients' needs. This included the development of a practice team comprised of different disciplines, and enhanced nurse practitioner roles to deliver high quality and responsive care for patients.
- There was a clear staffing structure in place. GPs and nurses had lead roles providing a source of support and expert advice for their colleagues.
- The practice had developed a range of policies and procedures to govern activity.
- The partners worked collaboratively with other GP practices in their locality, and with their CCG. Due to its location on the edge of the High Peak, hospital services were often quite remote for patients. The partners had instigated an independent provider service which relocated some NHS out-patient services into the community, making these more accessible for local residents. This approach was supportive of the local CCG strategy for 21st century patient care.
- The partners reviewed comparative data provided by their CCG and ensured actions were implemented to address any areas of outlying performance.
- Staff felt well supported by management, and the practice held regular staff meetings.
- The practice had sought feedback from patients, and acted on this to improve service delivery.
- There was an active Patient Participation Group (PPG) which acted as a critical friend to positively influence patient care and delivery. The practice worked well with their PPG and we saw evidence of how the PPG had contributed towards the achievement of good outcomes for patients.

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

Outstanding ☆

The practice is rated as outstanding for providing responsive and well-led services. The impact of this affected the quality of services provided to all patient groups and this led to an outstanding rating for all population groups.

- The practice directly employed their own care co-ordinator to facilitate the planning of care for patients being discharged from hospital, or to provide support to help patients remain in their own home.
- The needs of older people with more complex needs were reviewed via weekly care co-ordinator meetings and a monthly multi-disciplinary team meeting.
- Patients requiring support from clinical services such as physiotherapy were referred through a single point of access to ensure they received the individual care they needed.
- Longer appointment times could be arranged for patients with complex care needs at the request of the GP, or if reception staff knew patients might require additional time, they were booked in towards the end of the consulting session. Home visits were provided for those unable to attend the surgery.
- Due to the semi-rural location of the practice, transport links could be problematic for some patients. However, access to a local voluntary transport scheme provided patients with an opportunity to get to and from the practice more easily. Patients had to pay for fuel costs only.
- Uptake of the flu vaccination for patients aged over 65 was 72.8%, which was in line with local (73.9%) and national (70.5%) averages.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for providing responsive and well-led services. The impact of this affected the quality of services provided to all patient groups and this led to an outstanding rating for all population groups.

- The practice undertook annual reviews for patients on their long-term conditions registers, including a review of their prescribed medicines.

Summary of findings

- QOF achievements for clinical indicators were generally in line with CCG averages, and above national averages. For example, the practice achieved 96.8% for diabetes related indicators, in comparison to local and national averages of 96.7% and 89.2% respectively.
- A GP with a special interest in diabetes attended the practice each month to review patients with complex needs. In addition, a specialist diabetes nurse attended the practice bi- monthly to undertake a joint clinic with the practice nurse to assist with the management of other complex patients with diabetes. This process had helped to upskill the practice's nursing team in treating patients with diabetes. Performance data demonstrated the effectiveness of care including lower referrals to secondary care.
- The practice funded a specialist respiratory nurse to provide two days of clinical input each month. This nurse saw complex patients with breathing problems with the practice nurse. This provided additional expertise as well as providing a training development opportunity for the nursing team.
- The recall system was co-ordinated by the administration team, and we saw data that showed that patients received regular reviews of their condition including their prescribed medicines.
- Patients with multiple conditions were usually reviewed in one appointment to avoid them having to make several visits to the practice.
- There was a lead designated GP or nurse for the clinical domains within QOF.

Families, children and young people

Outstanding 

The practice is rated as outstanding for providing responsive and well-led services. The impact of this affected the quality of services provided to all patient groups and this led to an outstanding rating for all population groups.

- Same day rapid access was provided for babies or children who were ill.
- The midwife held a weekly ante-natal clinic and saw new mothers for a post-natal review at the practice.
- Childhood immunisation rates were in line with local averages. Rates for the vaccinations given to children up to five years of age ranged from 94.1% to 100% (local averages 95.2% to 99.1%).
- The practice had an identified lead GP for child safeguarding. The health visitor attended the practice multi-disciplinary team

Summary of findings

meetings on a monthly basis to review and discuss any child safeguarding concerns. Child protection alerts were used on the clinical system to ensure clinicians were able to actively monitor any concerns.
- Family planning services were provided on site. A clinic was held weekly between 5-6pm to enable better access for patients.
- The practice had baby changing facilities, and a small play area was available for children. The practice welcomed mothers who wished to breastfeed on site, and offered a private room to facilitate this if requested.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for providing responsive and well-led services. The impact of this affected the quality of services provided to all patient groups and this led to an outstanding rating for all population groups.

- The practice had identified that a large proportion of their patients were commuters, and designed access to accommodate this. This was facilitated by a system of triage, extended hours sessions, and telephone consultations. For example, the practice offered extended hours consultations each Tuesday evening to enable improved access for working patients.
- The practice offered on-line booking for appointments and requests for repeat prescriptions. The practice provided electronic prescribing so that patients on repeat medicines could collect them directly from their preferred pharmacy.
- The practice promoted health screening programmes to keep patients safe. NHS health checks were available.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for providing responsive and well-led services. The impact of this affected the quality of services provided to all patient groups and this led to an outstanding rating for all population groups.

- Patients with end-of-life care needs were reviewed at monthly multi-disciplinary team meetings. The practice worked closely with the district nursing team to deliver responsive and caring treatment and support to patients and their families.
- The practice proactively referred patients to the 'Wrap-around Care Project'. This provided a point of first contact to access the voluntary sector within the locality. Services available included

befriending, transport and shopping with the aim of keeping people independent in their own homes, or to regain confidence following a hospital discharge. The practice kept these patients under regular review to ensure their needs were being met.
- Staff had received adult safeguarding training and were aware how to report any concerns relating to vulnerable patients. There was a designated lead GP for adult safeguarding.
- The practice had undertaken an annual health review in the last 12 months for 50% of patients with a learning disability. The practice used symbols and pictures within letters to enable better understanding for patients with a learning disability.
- Travellers who resided on boats and barges at a nearby canal were able to register with the practice to ensure they had access to health care services.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for providing responsive and well-led services. The impact of this affected the quality of services provided to all patient groups and this led to an outstanding rating for all population groups.

- The practice directly employed a mental health support worker to provide social and mental health care and support for patients with poor mental health, including patients in their own home and within a local care home. The support worker could accompany patients to attend appointments to reduce their anxiety, and help with tasks such as completing forms to enable them to receive support for their condition. Data demonstrated the practice had the lowest rate of emergency admissions for mental health in the locality, and amongst the lowest across the CCG area.
- A nurse practitioner visited a care home specialising in dementia care twice each week. This care was supported up by named GPs, the mental health support worker, and the practice pharmacist. We were provided with examples of excellent patient care such as supporting patients and staff to enable a patient to have a dignified death within their care home setting. The impact of the nurse's input was supported by data showing reduced hospital admissions and access to out of hours care.
- The practice achieved 97.7% for mental health related indicators in QOF, which was 0.4% below the CCG and 4.9% above the national averages. Exception reporting rates for mental health related indicators were generally slightly higher than local and national rates.

Summary of findings

- 89.1% of patients with severe and enduring mental health problems had a comprehensive care plan documented in the preceding 12 months according to 2014-15 QOF data. This was slightly below the CCG average and marginally above the national average of 88.5%.
- There was access to counselling and associated talking therapies' services on site for one-and-a-half days each week. Patients could self-refer to this service as well as being referred by the GP.
- A psychiatrist saw complex mental health patients at the practice once a month. A community psychiatric nurse also attended these sessions.
- The practice worked with local community mental health teams and representatives regularly attended the multi-disciplinary team meetings.
- 74% of people diagnosed with dementia had had their care reviewed in a face-to-face meeting in the last 12 months. This was below local and national averages by approximately 10%. Exception reporting rates were lower at 5.6%, compared to the local and national averages of 8.8% and 8.3% respectively.
- Staff had received dementia awareness training from the Alzheimer's Society at a team meeting. The practice had plans to develop dementia friends training in the future.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016, and the results showed the practice was generally performing above or in line with local and national averages. There were 218 survey forms distributed to patients, and 124 of these were returned. This was a 57% completion rate of those invited to participate, and equated to 1.5% of the registered practice population.

- 96% of patients found the receptionists at this surgery helpful compared against a CCG average of 89% and a national average of 87%.
- 85% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 71% and a national average of 65%.
- 86% of patients said they would recommend this surgery to someone new to the area compared to a CCG average of 84% and the national average of 78%.
- 97% of patients said the last nurse they saw or spoke to treated them with care and concern compared against a CCG average of 94% and a national average of 91%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 24 comment cards which all contained extremely positive feedback in respect of the level of care provided. Many of the cards included accounts of how individual members of the practice team had provided exemplary treatment and support for patients and their families. Patients said they were treated in a dignified and respectful manner; that were given sufficient time to discuss their concerns; and that they felt listened to during their consultations. Three of the comment cards included a negative remark in relation to obtaining a routine appointment to see a GP, or to book a blood test.

We spoke with 11 patients during the inspection and the majority of these provided extremely positive comments regarding the caring and compassionate approach adopted by the practice team. Patients reported a high level of satisfaction regarding their consultations, stating that they were provided with sufficient consultation time and that they felt informed and involved in their care. Some patients commented on the nurse practitioner who they said took take time to explain treatment options to ensure patients fully understood their condition and health needs. One patient described how they preferred to see a female GP, and that this request was always accommodated by the practice. Patients mostly told us they were satisfied with the appointment system, although some stated that it was difficult to get through by telephone when the practice opened in the morning. However, others said that they rang later in the morning and found it easy to obtain an appointment.

Goyt Valley Medical & Dental 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 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 Goyt Valley Medical & Dental Practice

Goyt Valley Medical Practice provides care to approximately 8,200 patients in the High Peak area of North Derbyshire.

We visited the main site in Whaley Bridge for our inspection. There is also a branch site at Eccles Road, Chapel-en-le-Frith, High Peak, Derbyshire. SK23 9EQ.

The practice provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The site at Whaley Bridge operates from a purpose built two-storey building constructed approximately 30 years ago, and this was extended in 2006 to accommodate a dental service. All patient services are provided on the ground floor of the building, whilst the upper floor is utilised for administration.

The practice is run by a partnership of two GPs (one male and one female) who employ a full-time female salaried GP. This GP will shortly be joining the partnership.

The nursing team consists of two nurse practitioners, two practice nurses and two health care assistants. The practice directly employ a mental health support worker. The clinical team is supported by a practice manager, an administrator, a care co-ordinator, and a team of 15 administrative and reception staff.

A community pharmacist has been working in the practice since August 2016. This role has been initially funded as part of a national pilot project to provide pharmacy input within GP practices.

The registered patient population are predominantly of white British background with an age profile which is generally consistent with local averages, but has higher numbers of older people compared to the national average. The practice is ranked in the second least deprived decile and whilst situated in an area of relatively high affluence, it also serves an area with a prevalence of some industrial-related illnesses. The practice population includes commuters who work in nearby areas including Manchester, and a number of families from the farming community.

The practice's main site opens daily from 8am until 6.30pm, with additional extended hours being provided each Tuesday evening when the practice is open until 7.30pm. The branch site in Chapel-en-le-Frith opens every morning, and until 5pm each Monday, Wednesday and Friday afternoon. The practice closes on one Wednesday afternoon each month for staff training.

GP consultations commence each morning from approximately 8.30am to 11.30am. Afternoon GP surgeries usually run between 2.15pm until approximately 6pm. The last GP appointment during extended hours on Tuesday evenings is available at 7.15pm.

Detailed findings

The practice has opted out of providing out-of-hours services for its own patients. When the practice is closed, patients with urgent needs are directed via the 111 service to a locally based out-of-hours and walk-in urgent care centre in New Mills, operated by Derbyshire Health United (DHU). Patients also have access to a minor injuries unit in nearby Buxton. The closest Accident and Emergency (A&E) units are based in Macclesfield and Stockport.

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.

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

How we carried out this inspection

Before our inspection, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England and NHS North Derbyshire CCG to share what they knew.

We carried out an announced inspection on 20 September 2016 and during our inspection:

- We spoke with staff including GPs, a nurse practitioner, the practice manager, the care co-ordinator, the pharmacist, and a selection of reception and administrative staff. In addition, we spoke with a manager at a local care home, the health visitor, and the district nursing team manager, regarding their experience of working with the practice team. We also spoke with 11 patients who used the service.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 24 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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)

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective procedure in place for reporting and recording significant events

- A significant event reporting form was available to all staff electronically and in paper format. Seven significant events had been reported over the course of the last year.
- The practice encouraged staff to report incidents within a supportive 'no blame' culture.
- Completed forms were sent to the administrator to assess whether any urgent or remedial action was indicated to protect patients or staff.
- The practice arranged meetings to discuss incidents which usually involved the practice manager or administrator, a GP partner, and a member of the nursing team. Some issues would be tabled for further discussion at monthly clinical or general staff meetings. Discussions and outcomes were documented, and learning was shared with the practice team. An annual review of events was undertaken with the practice team and this provided an opportunity to ensure all agreed actions had been completed, and to review any recurrent themes that may have emerged.
- We saw examples of learning that had been applied following a significant event. For example, there had been an incident involving temperature readings in the refrigerator containing vaccines. This resulted in some vaccines being destroyed and patient appointments having to be re-scheduled. However, the practice took several actions to strengthen their monitoring procedure and when a further incident occurred due to loss of power, the practice was able to deal with the issue more promptly and effectively.
- People received support and an apology when there had been unintended or unexpected safety incidents. The practice informed us they would either meet with the person or write to them, depending on the particular circumstances involved.
- A GP partner, the practice manager and a senior administrator had attended a course by the NHS Institute for Innovation and Improvement called Leading Improvement in Safety and Quality (LISQ). This had helped to raise the profile of incident reporting within the practice.
- Learning from significant events was often shared at locality meetings with other practices. This included a review to establish the feasibility of having centrifuges within the practice to avoid false blood readings, and unnecessary hospital admissions for patients.

The practice had a process to review alerts received including those from the Medicines Health and Regulatory Authority (MHRA). This was supported by a written safety alerts protocol, and we saw evidence that alerts were discussed at clinical staff meetings. When concerns were raised about specific medicines, patient searches were undertaken to identify which patients may be affected. Effective action was taken to ensure patients were safe, for example, by reviewing their prescribed medicines. The practice-based pharmacist was to take over responsibility for this task and ensure a more complete audit trail was available to evidence all actions taken.

Overview of safety systems and processes

The practice had defined systems and procedures in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local guidance. Practice safeguarding policies were accessible and up-to-date, and alerts were used on the patient record to identify vulnerable children and adults. There were designated lead GPs for safeguarding both children and adults, who had received training at the appropriate level in support of their lead roles.

The health visitor attended a monthly multi-disciplinary team meeting to discuss any child safeguarding concerns. Minutes of this meeting were available. We spoke with a member of the health visiting team who informed us that there was effective liaison with the practice, and that they worked in collaboration should any issues be identified. Practice staff demonstrated they understood their responsibilities and all had received training relevant to their role. We were provided with a recent example where a GP had taken action when safeguarding concerns had been identified to ensure the safety and welfare of the child.

Good

Are services safe?

Vulnerable adults were monitored by the practice team and staff were aware how to report any safeguarding concerns regarding adults. Clinicians were able to describe how they had acted to safeguard adults and documented their actions, taking account of the patient's preferred wishes.

- A notice in the reception and the consulting rooms advised patients that a chaperone was available for examinations upon request. A health care assistant who had received training to support this role, would normally act as a chaperone if a nurse were unavailable. Staff who undertook chaperoning duties had received a disclosure and barring check (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).
- We observed that the practice was tidy and maintained to good standards of cleanliness and hygiene. A GP was the appointed infection control lead, supported by the nursing team. The GP was arranging some additional training to support the lead role. Quarterly infection control meetings took place and these meetings were documented. There were infection control policies in place, including needlestick injuries and the handling of samples, and we observed these had been reviewed regularly. Practice staff had received infection control training, and received information as part of new staff inductions. An infection control audit had last been undertaken by the practice nurse in September 2016, and this was supported by a comprehensive action plan to address the issues identified. We observed that actions had been signed and dated as they had been completed. A handwashing audit had also been undertaken.
- The practice used contractors to provide their cleaning services and written schedules of cleaning tasks were available. The administrator met with a representative from the cleaning contractor every month to undertake a cleaning audit jointly, and discuss any issues relating to the service being provided. Audits demonstrated that standards were regularly attaining scores above 90%. Documentation was available to support the control of substances hazardous to health including any spillages.
- We reviewed three staff files and found that the necessary recruitment checks had been undertaken prior to commencing work with the practice. For example, proof of identification, qualifications, registration with the relevant professional body and the appropriate checks through the DBS. The files were maintained to an excellent standard with all information being easily retrievable. The files contained a checklist to ensure that all the required documentation was available and up to date.
- We saw evidence that clinical staff had received vaccinations to protect them against hepatitis B. Non-clinical staff had been offered this vaccination, and most staff had received this, although the practice operated a 'no touch' policy with reception staff.
- The practice had an effective system to manage incoming correspondence to ensure that any actions, such as a change to a patient's medicines, were completed promptly. GPs ensured that they reviewed the pathology results for their colleagues if they were absent.

Medicines management

- The arrangements for managing medicines in the practice, including emergency medicines and vaccinations was safe.
- Blank prescription forms and pads were securely stored and monitored.
- There was a process in place to support the safe issue of repeat prescriptions. Repeat prescription requests were placed in an open and unsecured box on the reception desk. The practice told us they would review this immediately when raised with them.
- Regular medicines stock checks including expiry dates were undertaken.
- Signed and up-to-date Patient Group Directions were in place to allow nurses to administer medicines in line with legislation.
- Systems were in place to monitor patients prescribed high-risk medicines. Monitoring included a nurse practitioner led INR service for patients prescribed medicines to control anti-coagulation (the clotting of blood). Controlled drugs and benzodiazepines were actively managed to monitor any requests for early repeats, and to review if individual patients could reduce the dose and quantity of prescribed medicines. An audit was planned to assess the outcomes this had achieved.
- Any uncollected prescriptions left at the surgery, or returned from the pharmacy, were reviewed by the pharmacist with appropriate follow up action being taken.

Good

Are services safe?

Monitoring risks to patients and staff

- A practice health and safety policy was available and the practice fulfilled their legal duty to display the Health and Safety Executive's approved law poster in a prominent position.
- The practice utilised an independent contractor to provide health and safety advice and support. The contractor undertook a full assessment of the building annually and this resulted in a comprehensive action plan. We observed that the practice had completed and recorded all the actions that had been identified.
- A variety of risk assessments were available to proactively manage any new or emerging risk areas. This included risk assessments for home visits, and lone working. The practice ensured this process was kept updated, for example, by adding any new risks that may have been identified through the incident reporting procedure.
- A fire risk assessment had been undertaken in April 2016. This had resulted in an action plan and we saw evidence that the practice had responded to all the issues that had been identified. Fire alarms and extinguishers were serviced regularly to ensure they were in full working order. Staff had received fire training, both on line and face-to-face, and the practice undertook regular trial evacuations to ensure staff were aware of the procedure to follow in the event of a fire.
- All electrical equipment was regularly inspected to ensure it was safe to use, and medical equipment was calibrated and checked to ensure it was working effectively. We saw certification that this had been completed by external contractors in the last 12 months.
- The practice had completed a risk assessment for legionella in November 2015 (legionella is a term for a particular bacterium which can contaminate water systems in buildings). We saw evidence of regular running of infrequently used water sources which was supported by documentation.
- There were arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. Rotas were organised and any problems were reviewed at the partners meeting, for example, to consider if locum GP support was required. The practice also had access to a nurse practitioner locum.

Arrangements to deal with emergencies and major incidents

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

- Staff had received annual basic life support training. We saw evidence that the team had received this training in March 2016. The training was provided over three sessions to ensure the whole team were able to attend.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and were in date. However, emergency medicines were not taken on home visits, and there was no risk assessment in place to cover this.
- A first aid kit and an accident book were available.
- An emergency alert system on computers informed staff to assist rapidly with any emergency situation, such as if a patient was to collapse.
- The practice had a business continuity plan for major incidents such as power failure or building damage. This was regularly reviewed, most recently in August 2016. Copies of the plan were kept off site in case any incidents made entry to the site inaccessible. As the practice had a branch site, there were arrangements to ensure continuity of service and access to records if one site was temporarily out of action. The practice had also identified two other local sites which could be accessed as a base in case of emergency.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and local guidance. New guidance was discussed at monthly clinical staff meetings and learning lunches. Learning lunches had been established to provide a forum for feedback to colleagues following attendance at meetings such as prescribing committees and clinical governance meetings. In addition, clinical staff might present a journal article; feedback from their attendance on a course; or to present a patient story. This contributed to an environment of continuous learning within the practice. Recent training topics that had been discussed at the learning lunches included the management of vertigo, and the assessment of suicide risk for patients with depression.

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 (2014-15) were 99.1% of the total number of points available. Exception reporting rates at 7.7% were below the local average of 11% and the national average of 9.2%. Exception reporting is the removal of patients from QOF calculations where, for example, a patient repeatedly fails to attend for a review appointment. A low figure for exception reporting usually demonstrates a proactive approach from the practice to engage patients in attending for regular reviews of their condition.

QOF data from 2014-15 showed:

- Performance for diabetes related indicators was 96.8%, which was in line with the CCG average of 96.7% and above the national average of 89.2%. This was achieved with lower exception reporting rates at 5.3% (local 13.4%; national 10.8%)
- The practice achieved 100% for clinical indicators related to chronic obstructive airways disease. This compared to a local average of 99.2% and a national average of 96%
- QOF achievement for 2014-15 for asthma was 100% which was slightly higher than local and national averages (97.6% and 97.4% respectively).
- Dementia related indicators scored 97.7%. This was in alignment with the CCG and 3.2% higher than the national average. Exception reporting rates were approximately 3% below local and national averages.

Practice supplied data (subject to external verification) demonstrated that high QOF achievement had been maintained in 2015-16.

There was evidence of quality improvement including a programme of clinical audit.

- The audit programme included specified annual audits such as inadequate cervical smears, the use of inhalers, and smokers over the age of 35 being prescribed the contraceptive pill. We saw that three clinical audits had been undertaken in the last year. One of these was a completed full-cycle audit where changes had been implemented and monitored with positive outcomes for patients. The full cycle audit was undertaken on patients with atrial fibrillation (an irregular heart rate) who had been prescribed aspirin, as this is no longer recommended as a medicine to be used to thin blood for most patients with this condition. The audit demonstrated that all 18 patients who had been identified had received an appropriate review of their medicines and were no longer taking aspirin in line with the NICE guidance. Three further patients were identified during the second cycle and plans were in place to review their medicines regime.
- The practice funded a respiratory nurse to see patients with complex respiratory problems. The nurse had undertaken an audit of patients with asthma to ensure they were not taking excessive amounts of short-acting inhalers to manage their condition, in line with guidance. This had identified approximately 70 patients whose condition and medicines regime was then reviewed to ensure a safe and appropriate plan of care was in place.
- The practice worked with a CCG medicines management pharmacy technician who visited approximately every three weeks and carried out medicines audits to ensure prescribing was cost

effective, and adhered to local guidance. Data demonstrated that the practice's performance for prescribing was good and in alignment with local averages.

- The practice participated in local benchmarking activities. For example, they participated in annual quality focussed visits with the CCG to review comparative data including referral rates and hospital admissions.

The nurse practitioner provided twice-weekly visits to a care home for patients with dementia since November 2013. The nurse had worked collaboratively with care home staff and other professionals to deliver good outcomes for patients. For example, data showed that the number of hospital admissions fell from 67 over one year in November 2014, to 43 by November 2015. Contact with the out of hours' service reduced from 23 in November 2014, to 17 the following year. Other outcomes showed a decrease in falls from 56 between January to March 2014, to 24 in the corresponding period the following year. There was also a demonstrable reduction in medicines management waste by a more structured approach to the ordering of repeat medicines. The care home manager explained how the nurse practitioner had empowered staff to make confident decisions and reduce their reliance on hospital and out of hours care providers.

Effective staffing

- The practice had reviewed the needs of their patients and created an effective skill mix within their team to provide optimal patient care. It also created a flexible and responsive service with regards to access to on-the-day appointments, advance bookings, and telephone advice to all patient groups. The skill mix of the team included:

- Two nurse practitioners who provided on-the-day assessment and care for patients presenting with new and acute conditions, and minor illnesses. This created more capacity for the GPs to manage complex conditions and to follow up any issues identified by the nurse practitioners. The nurse practitioners undertook home visits and there was a practice protocol in place for this. A nurse practitioner also provided regular input to a local care home. Nurses had completed master's level qualifications in first contact care in support of this role. The success of the scheme was demonstrated in an audit which showed a reduction of 20% in the need for back-up support from GPs during consultations.
- A mental health support worker who provided social and mental health care and support for vulnerable patients with poor mental health. This support had prevented deterioration in patients' mental health which might otherwise have led to increased morbidity and increased reliance on psychiatric services. The practice had also employed a community psychiatric nurse but due to changes in funding arrangements, this post had been moved to a health trust. Consequently, outcomes were in the process of being reviewed but data for emergency admissions for mental health over a three year period showed low figures for the practice. These were the lowest within their locality and one of the lowest within their CCG. The practice were able to provide evidence that over the last two years, only four of 22 patients at high risk of hospitalisation had been admitted, with two of these being outside of the practice's direct control due to other circumstances.
- A community pharmacist had commenced working at the practice in August 2016 as part of a national pilot project to provide pharmacy input within GP practices. This helped to deliver safe, appropriate and cost-effective prescribing, and provided patients with an alternative option to consult and discuss their medicines requirements with a professional other than a GP.
- A care co-ordinator who supported vulnerable patients with a long-term health condition by arranging weekly team meetings to review care plans, including support packages and clinical input.
- In addition, a community matron has recently been appointed by the community health service provider. The practice had extensive discussions with the community provider to ensure an integrated approach into how this role would be implemented. It had been agreed that the matron would be employed by the community provider, but the managerial responsibilities would be shared with the practice to ensure integrated working. For example, appraisals would be undertaken jointly by the practice manager and community services manager.

- The practice provided an induction programme for all newly appointed staff. We reviewed comprehensive

examples of these which were specific to individual roles, and we saw evidence that topics were signed off once completed. Staff told us they were well supported when they commenced their roles with shadowing opportunities and had easy access to support from their colleagues.

- Staff told us that they received an annual appraisal and we saw comprehensive documentation that evidenced this. We spoke to members of the team who informed us of how learning opportunities had been discussed during the appraisal and supported by the practice. For example, the practice administrator informed us how the role had developed from initially being appointed as a receptionist. The practice was supporting this individual in undertaking a degree and providing them with opportunities to develop their managerial skills. A receptionist informed us how they had taken on the co-ordination of asthma reviews after requesting to take on a new area of responsibility at their appraisal.
- The practice ensured role-specific training with updates was undertaken for relevant staff; for example administering vaccinations and taking samples for the cervical screening programme.
- Staff received regular training that included safeguarding, fire safety awareness, and basic life support. Staff had access to and made use of e-learning training modules and in-house training. The practice had protected learning time on one afternoon each month, when in-house training was organised for the practice team. GPs attended training events organised by their CCG on some of these months. We observed that the practice maintained a full record of staff training and reviewed this to ensure update training was scheduled in advance. The practice had a development plan in place to support the training needs of their nursing team.
- We observed examples of training being undertaken jointly with the dental team, and also the nurse practitioner had undertaken end of life care training with two managers from the care home at the local hospice.
- Clinical staff received support and mentorship in their roles, for example in relation to prescribing support for the nurse practitioners and pharmacist.
- Staff rotated across the two sites. This ensured no one was isolated and everyone was integrated within the practice team.

Coordinating patient care and information sharing.

- The information needed to plan and deliver care and treatment was available to clinicians in a timely and accessible way through the practice's electronic patient record system. This included care plans, medical records, and investigation and test results. We viewed examples of care plans and saw that these were comprehensive and appropriate.
- Monthly multi-disciplinary meetings were held at the practice to assess the range and complexity of patients' needs, and to plan ongoing care and treatment for vulnerable patients including those at high risk of hospital admission. The meeting also provided the opportunity to discuss any child safeguarding concerns, and to review the care of any patients receiving palliative care. Practice representatives at this meeting included members of the practice team, the health visitor, a social worker, district nursing team staff, and a representative from the community mental health team. Minutes were produced from the meeting that were made accessible to all attendees. Providers of community based services were invited to this meeting to raise awareness of what was available, and to establish effective communication channels. Examples included the hospice at home service, falls service, fire service, and a variety of voluntary schemes.
- In addition to the monthly multi-disciplinary meeting, the practice's care co-ordinator had a weekly meeting with a designated lead GP, a representative of the community nursing team and the social worker. This provided time to review vulnerable patients in more depth to ensure that their individual needs were being addressed adequately. Minutes were available to ensure that all clinicians had access to relevant information.
- Monthly meetings were held to focus specifically upon the needs of end of life care.
- Monthly clinical staff meetings reviewed clinical issues, significant events and complaints.
- Nursing staff had their own additional monthly meeting.
- The practice worked collaboratively to enhance patient care and outcomes. For example, a specialist diabetes nurse and a GP with a special interest in diabetes provided regular input at the practice to enhance outcomes for patients. The practice was able to demonstrate the effectiveness of these interventions in being the third lowest of 37 practices within the CCG in

terms of referrals to hospital based out-patient services. In addition, the practice was ranked the second highest within the CCG for achieving three specific treatment targets as part of the national diabetes audit.

Consent to care and treatment

- Staff sought patients' consent to care and treatment in line with legislation and guidance.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs).
- When providing care and treatment for children and young people, staff followed national guidelines to assist clinicians in deciding whether or not to give sexual health advice to young people without parental consent.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- The practice hosted a weekly session on site provided by the 'Live Life Better Derbyshire' service. This offered assessments for patients over 16 years of age to provide advice and signposting to relevant support schemes, for example, to stop smoking and to assist in weight management and promote more active lifestyles.
- The practice provided new patient health checks, and NHS health checks for patients aged 40-74. Well woman and well man clinics were provided in the surgery.
- The practice's uptake for the cervical screening programme was 81.3%, which was in line with the national average of 81.9%, but slightly below the CCG average of 84.1%. Exception reporting was lower at only 1.1% (2.9% CCG; 6.3% nationally).
- National screening programme data showed the uptake for bowel cancer screening was in line with local averages, and slightly higher than national averages. However, screening for breast cancer was lower compared to local averages. The practice explained that this was problematic as patients had to attend Chesterfield, which was located several miles away, and local transport was sometimes difficult to the practice location within the High Peak. A mobile breast screening unit was available but offered little flexibility in appointment availability. The practice did actively promote attendance both through consultations and by information on display. The practice was also aware that they had a number of patients who would access this service privately, and therefore would not be included within the data available.
- Childhood immunisation rates for the vaccinations given to children aged up to five years of age were in line with average figures. The overall childhood immunisation rates for the vaccinations given to under two year olds ranged from 97.1% to 100% (local average 95.2% to 98.9%) and five year olds from 94.1% to 96.5% (local average 96.5% to 99.1%).

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations and treatments.

Throughout our inspection, we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect. A caring and patient-centred approach was demonstrated by all staff we spoke with during the inspection.

Feedback received via comment cards, and from patients we spoke with on the day, told us that patients were listened to and supported by staff. Patients consistently said that they were treated with compassion, dignity and respect by clinicians and the reception staff. Results from the national GP patient survey in July 2016 showed the practice was higher than local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 96% of patients said the last GP they saw was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 96% of patients said the last GP they saw gave them enough time compared to the CCG average of 90% 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 97% and the national average of 95%.
- 95% of patients said the last GP they spoke to was good at treating them with care and concern compared to a CCG average of 90%, and the national average of 85%.

We spoke with managers of the district nursing team and care home who reported that the practice team were patient-centred, accessible, and respectful of their opinions.

We were provided with examples of how the practice provided ongoing care and support to their most vulnerable patients. For example, the care co-ordinator maintained weekly telephone contact with a patient attending a specialist unit for cancer care. This provided an opportunity to check how the patient was feeling, to determine any new or additional needs, and to ensure that transport arrangements were working as required.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in decision making about the care and treatment they received, and feedback on the patient comment cards we received aligned with these views.

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

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87%, and the national average of 82%.

Patient and carer support to cope emotionally with care and treatment

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, and those at risk of developing a long-term condition.

Notices in the patient waiting room told patients how to access a number of support groups and organisations, and a range of literature was available for patients.

The practice had coded 3.5% of the practice list as carers. At the time of our inspection, the practice was undertaking an exercise to review their carers register to ensure this was accurate for example, following patient deaths. The practice identified new carers upon registration, and carers' information packs were available. The practice had identified a designated 'Carers' Champion', although this role was under development. The practice encouraged carers to receive vaccination against the flu virus, and as part of their action plan, they planned to invite each carer to attend an annual review to discuss any health concerns they may have. Signposting details for carers were available in the reception area.

Good

Are services caring?

The practice worked with the wider multi-disciplinary team to deliver high quality end of life care for patients, and held monthly Gold Standard Framework (GSF) meetings. The GSF improves the quality, coordination and organisation of patient end of life care, leading to better outcomes in line with their needs and preferences, and reducing hospitalisation. The manager of the district nursing team informed us that GPs were easily accessible and responded effectively to any requests for support in the ongoing care of patients with palliative care needs.

Patient deaths were reviewed at weekly partner meetings and the GP with the most contact would usually visit or call the relatives to offer condolences. Information was provided to signpost relatives or carers to appropriate services such as counselling where indicated. There was information about bereavement support in the waiting area.

We were informed how the nurse practitioner had enabled a dignified death within the care home by working collaboratively with the care home staff. This helped to prevent the patient from being admitted into hospital and ensured they were cared for in a known and peaceful environment with staff they were familiar with.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice 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 was involved in the GP Pharmacy Transformation Programme to provide a prescribing community pharmacist within the practice. This offered an alternative approach, for example, in the monitoring of patients taking high-risk medicines, and conducting medicines reviews such as for those patients with a long-term condition. This gave better access for patients, and expert advice and support on medicine-related issues.
- The practice had formed an independent company with two other local GP practices that provided a range of out-patient and diagnostic services which were delivered from the branch surgery in Chapel-en-le-Frith. This included NHS out-patient clinics such as dermatology, ophthalmology, rheumatology, gynaecology and an ultrasound diagnostic service. The facility enabled patients to access high quality health care within the High Peak area and avoided a potential long journey to the hospital, which was located several miles away.
- The practice provided a range of services that ensured these were easily accessible for their patients. This included phlebotomy (taking blood); clinics to review the treatment of patients prescribed medicines to thin their blood; screening and prevention advice for osteoporosis; ECGs to test the heart's rhythm; 24 hour blood pressure monitoring; family planning clinics (including coil and implant procedures); travel vaccinations; and performed some limited minor surgery including joint injections.
- The practice hosted some services on site to facilitate better access for patients. This included a weekly ante-natal clinic by the midwife, and counselling services and talking therapies for patient experiencing mental health difficulties.
- All of the consulting rooms were accessed on the ground floor. The site was accessible for patients with reduced mobility, and there was access to a hearing loop system within reception for patients with a hearing impairment. Information could be provided in braille or easy read format upon request.
- The waiting area contained a good range of information on local services and support groups. This included information for carers, support with bereavement, and local services available for patients with mental health issues. Health promotion material was displayed within the waiting area, and this was updated regularly. The practice was promoting the next flu campaign at the time of our inspection.
- A log in touch screen was available for patients upon arrival. A television was provided within the waiting area. There were plans in place via the CCG to incorporate health information and advice to be displayed via the television screen.
- The co-location of the GP practice with a dental practice created joint working opportunities and benefits for patients. For example, practice and dental staff would sometimes take part in joint training. In addition, dental staff told us that if they saw a patient and had any health-related concerns, they could direct the patient (as long as they were registered with the GP practice) to be seen within the practice at the time.
- Same day appointments were available for children and those patients with medical problems that required them to be seen urgently. Home visits were available for older patients and others with appropriate clinical needs which resulted in difficulty attending the practice.
- The practice provided care for residents at a local care home for patients with dementia. A nurse practitioner visited the home twice each week, and any patients with urgent needs would receive a visit from a GP. All patients had a named GP and each GP would undertake a quarterly visit to the home with the nurse practitioner to review their own list. Care plans were in place for all patients, and relatives and carers were involved in the planning and review of patients' needs. The manager at the home informed us they were highly satisfied with the service provided and the continuity of care in place for their residents.
- Patients could be moved into a private room besides the main reception desk for confidential discussions.
- The practice had a patient information leaflet and website which were both being updated, with the PPG had been involved throughout this process.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Patients could order repeat prescriptions on line. The practice participated in the electronic prescription service, enabling patients to collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- Translation services were available for patients whose first language was not English.

Access to the service

The practice's main site opened daily from 8am until 6.30pm with extended hours opening until 7.30pm on a Tuesday evening for both GP and nurse appointments. The practice closed on one Wednesday afternoon each month for staff training.

GP consultations commenced in the morning from approximately 8.30am to 11.30am. Afternoon GP surgeries usually ran between 2.15pm until approximately 6pm. The last appointment during extended hours on Tuesday evenings was at 7.15pm.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mostly above local and national averages.

- 85% of patients found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 93% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 88% and a national average of 85%.
- 86% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 54% of patients usually got to see or speak to their preferred GP, compared against the CCG average of 60% and national average of 59%.
- 75% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.

The nurse practitioners acted as the first point of contact for patients with a new health problem. They provided a daily triage service and would see any patient requiring an appointment that day via a face-to-face consultation, either in the surgery or at the patient's home. This was backed-up by an effective system of safety-netting (actions put in place during the consultation to ensure patient safety) and access to GP advice as required. This enabled GPs to consult with the more complex patients or those individuals who required follow-up for their treatment. However, patients were offered a choice and this included seeing a GP if that was their personal preference. As the nurse practitioner role had become embedded, patients understood how this process worked and we received positive feedback from them about their experience in seeing the nurse, and many patients preferred this option.

Staff informed us that patients could book up to four weeks in advance to see a GP or a nurse. On the day of our inspection, we saw that the next available routine GP appointment was available that day, and several appointments were free for the rest of the week.

Listening and learning from concerns and complaints

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

- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated person that co-ordinated the complaints process. Clinicians always reviewed any complaints of a clinical nature.
- We saw that information was available to help patients understand the complaints system in the waiting area.

We looked at seven complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency.The practice offered to meet with complainants to discuss their concerns whenever appropriate. Complaints were sometimes incorporated into the significant incident review process to ensure greater analysis of the factors that led to the complaint being raised. Lessons were learnt and shared with the team following concerns and complaints, and action was taken to as a result to improve the quality of care. For example, the practice had received a complaint with regards the recording of weight as part of the ongoing monitoring of a condition. The patient felt this was being made an issue by one nurse, as another clinician had not recorded this. Therefore, to ensure consistency, it was agreed that weight would be recorded as part of all subsequent health checks with the caveat that patients could always decline to have this.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

- The service had produced a practice vision. This had been developed by the practice team during a staff away day. The partnership had also produced written aims and objectives. There were plans to review these when the third GP joined the partnership in the near future.
- The practice held a weekly partners' meeting with the practice manager and administrator. This reviewed key issues relating to the practice business, and the meetings were documented.
- The practice had developed an outline of their key priorities which formed their basis of their future strategic direction. The partners and practice management could articulate a clear vision for the future and they demonstrated a strong passion for continuous quality improvement which was inherent within their work.
- The practice worked with other local GP practices, and was part of a local GP federation which met each month and provided a collaborative forum for future service planning. The practice manager was one of five directors within the federation.

Governance arrangements

The practice had an effective governance framework which supported the delivery of good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear team structure in place, and staff were aware of their own roles and responsibilities. All GPs and nurses had defined lead clinical areas of responsibility. Reception supervisor roles had been recently introduced to manage and co-ordinate reception duties.
- Systems were mostly in place for identifying, recording and managing risk, and implementing mitigating actions.
- A wide range of practice specific policies had been implemented, and were available to all staff.
- An understanding of the performance of the practice was maintained which included the analysis and benchmarking of QOF performance, and referral and prescribing data. Actions were undertaken when any variances were identified.
- The practice manager maintained comprehensive documentation to ensure evidence was available to support their compliance with standards. This included minutes from meetings, completed action plans, and comprehensively maintained staff files. Information was stored to make it accessible and easy to understand. A forward schedule was in place to identify when specific tasks required an update.

Leadership and culture

- Partnership arrangements had recently changed with the retirement of a long-established partner. The practice had adapted to this and continued to provide a high quality service without any impact for patients. A new partner was due to join the partnership shortly after our inspection, this reflected on the reputation of the practice with the current GP recruitment difficulties and the semi-rural location of the practice.
- The practice had previously been commissioned through a different type of contract which had enabled the partners to directly employ a large and varied clinical team including a pharmacist, health visitors, district nurses and a community psychiatric nurse. When contractual arrangements changed, funding arrangements meant that many staff had been re-located within different health provider organisations. This had created a significant change in the way that the practice had to work, and to absorb some of the responsibilities undertaken by the previously employed staff. The practice had risen to this challenge and had adjusted its skill mix to meet their patients' needs. In recognition of the value that these roles had delivered, the partners had continued to employ a mental health support worker, and had recently managed to secure pharmacy input back into the practice as part of an initially funded pilot scheme. The partners emphasised the value of their wider skill mix and the contribution this made towards patient care. This was kept under constant review and a third nurse practitioner had recently been appointed. The practice also considered succession planning arrangements and this included an ongoing review of what was needed to replace some vacant salaried GP hours. There was a commitment to ensure the right person was appointed to any role and fitted in with the team's values, and the practice subsequently did not rush the recruitment process. For example, the new

Are services well-led?

Outstanding ☆

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

nurse practitioner would not commence their post until April 2017 but the partners were happy with this arrangement, as they knew the post holder would bring particular expertise to complement their existing team.

- New ways of working were embraced to adapt to emerging demands. This was demonstrated by the empowerment of the nurse practitioner role to act as a first contact to see patients.
- A nurse practitioner was a Queen's Nurse. This title is awarded to community nurses who support innovation and best practice to promote the highest standards of patient care. The role created networking opportunities which helped the practice to continuously enhance quality and to keep up to date with new developments.
- The practice engaged with their CCG and worked with them to enhance patient care and experience. One partner attended the monthly locality meetings with other local GP practices and CCG representatives, and another GP attended the Clinical Governance Leads meetings. The practice manager attended the local practice managers' meetings.
- The partners and practice management were able to demonstrate they had the experience and capability to run the practice effectively to ensure high quality care. All clinicians had defined areas of lead responsibility for particular clinical and managerial functions. The practice used an external contractor for expert health and safety advice and support.
- The practice ensured that services were reviewed regularly in order to resolve any problems promptly and effectively. This included a quarterly management review with the care home manager, and the practice manager met the manager of the community nursing team on alternative weeks.
- Staff told us there was an open culture within the practice and said the partners and practice manager were visible within the practice and were approachable, and always took the time to listen to all members of staff. Staff said they felt respected, valued and supported by the partners and managers in the practice.
- Staff told us the practice held monthly meetings during their allocated protected learning time. They had the opportunity to raise any issues at these meetings and felt confident and supported in doing so. The team would meet together and use this as an opportunity to review incidents and participate in mandatory or other general training applicable to the whole team. Minutes from this meeting were documented.
- Staff we spoke with told us that the practice was a good place to work, and the team supported each other to complete tasks. The practice organised an annual team building event outside of work, and this had most recently been a hog roast which was attended by practice staff and their families. There was a low turnover of staff at the practice, and many members of the team had worked there for a number of years.
- The practice had established some links with their local community. For example, the location within the High Peak created some difficulties to service delivery during the winter months. The practice had arrangements with local farmers and the Peak Rangers to help gain access to patients in rural locations during more extreme weather conditions. Additionally, the mental health support worker had established links with local community support groups.

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.

- The practice had gathered feedback from patients through patient surveys; via complaints received; a suggestion box; and responses received as part of the Families and Friends Test (FFT).
- The practice undertook their own internal patient survey on at least an annual basis and discussed the results with their Patient Participation Group (PPG). An outcome from the most recent survey included increasing the availability of more pre-bookable appointments for patients. This would include the trialling of pre-bookable nurse practitioner appointments in addition to GP appointments, when the third nurse practitioner commenced work.
- The practice had an active PPG with a core membership of eleven members who regularly attended meetings every two months. There was a wider virtual group of 16 patients who received information via e-mail and were invited to comment on any relevant issues raised at the meetings. The practice manager and senior administrator would always attend the PPG meetings, and a GP would usually try to be present. The practice had a dedicated PPG noticeboard displayed within the reception area, and provided information about their

Are services well-led?

Outstanding ☆

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

work on the practice website. We spoke with two members of the PPG, including the chair, and they described a very positive relationship with the practice. They said the practice listened to them and made changes wherever this was possible. The PPG had influenced a change to the message used on the answer phone, and had undertaken fund raising to buy new toys for the waiting area. The PPG were developing links with the community to raise the profile of their work and gather feedback on the GP service. This included liaison with the Women's Institute and Mothers and Toddlers group.

- 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 provided placements for fourth year medical students. We saw the results of a feedback survey from Manchester University which demonstrated that the students evaluated the practice highly, scoring 4.98 out of 5 for 2015-16. This was slightly higher than the average figure.

Continuous improvement

The practice had a history of continuous improvement. Further to changes to a previous contract which had offered great flexibility in directly employing a number of clinical staff, the partners had worked to establish a model focused towards the needs of their patients. This included:

- The development of the nurse practitioner role in relation to access, and support for patients with dementia in a local care home.
- Participation in the national pharmacy pilot to place a community pharmacist within the practice team.
- The direct employment of a mental health support worker in recognition that patients with less complex mental health needs could be well-managed in their own home with regular contact and support.
- There was shared managerial responsibility with the community provider for the newly appointed community matron. This ensured the matron was integrated within the community nursing team whilst providing a tailored service to meet the practice's requirements. The model which provided jointly developed programmes for induction and annual appraisal between the employer and the practice was an excellent example of integrated working.
- The practice reviewed gaps in care which would then be addressed to enhance patient care and experience. For example, the practice were looking to fund some sessions for a nurse to provide routine leg ulcer dressings to ensure this service could be accessed locally by patients.