Bakewell Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 8

What people who use the service say 14

Areas for improvement 14

Outstanding practice 14

Detailed findings from this inspection

Our inspection team 16

Background to Bakewell Medical Centre 16

Why we carried out this inspection 16

How we carried out this inspection 16

Detailed findings 18

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bakewell Medical Centre on 12 May 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing safe, effective, caring and responsive services. It was outstanding for well led and for providing services for all the population groups we inspected.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used proactive methods to improve patient outcomes, working with other local providers to share best practice. This included work related to hospital admission avoidance and end of life care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. Succession planning was in place, monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice:

Summary of findings

- Patients were protected by a strong safety focus and robust systems were in place to safeguard patients from abuse. For example, the practice had used the Manchester Patient Safety Framework (MaPSaF) as a basis for developing their error reporting protocol. This had promoted a genuinely open culture in which all safety concerns were highly valued and integral to learning and improvement. The MaPSaF helps healthcare organisations to reflect on their progress in developing a mature safety culture.
- The practice had an established and embedded process for multi-disciplinary working to deliver integrated care that was centred around the patients' needs and experience. As a result, robust systems were in place for effective care planning and on-going reviews of patient's individual health needs and medicines.
- Outcomes for patients were consistently higher when compared with other similar services and the national average. his included: lower rates for emergency admissions, out of hours usage and attendance of Accident and emergency (A&E) services which were below local and national averages.
- The admissions avoidance work had a strong focus on improving outcomes for patients at most risk of unplanned admissions to hospital and preventative care arrangements were in place. This ensured patients could continue being cared for in the community. The practice had identified 4% of the patients at most risk which was above the contractual requirement of 2%.
- One of the GP partners had led innovations across the CCG area to drive improvements in respect of end of life care. This showed the GP had a strong commitment to improving the outcomes for patients in the wider locality. The practice showed a high level of commitment to the needs of patients receiving palliative care and recognised that many of them wanted to receive the highest quality of care and support to enable them to die with dignity in their own home or care home. Effective and robust systems were in place to ensure they received their end of life care in line with their expressed preferences.

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

Importantly the provider should

- Ensure clinical audits in respect of contraceptive implants and minor surgery are undertaken regularly in line with best practice guidance.

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?

Outstanding ☆

The practice is rated as outstanding for providing safe services.

The practice had used the Manchester Patient Safety Framework (MaPSaF) as a basis for developing the practice's error reporting protocol and facilitating "a team based self-reflection and educational exercise on improving patient safety culture". As a result, staff were fully committed to reporting of incidents and near misses; as well as improving the safety culture within the practice.

Every opportunity to learn from internal incidents and significant events was used by staff to improve patient care and outcomes. Improvement work had been undertaken in respect of medicines management and error reporting to ensure patients received safe care.

The processes in place for monitoring safety and risk management were comprehensive and had been improved when needed. This included infection and control practices, use of equipment and arrangements to deal with emergencies and major incidents. Suitable recruitment procedures were in place to ensure fit and proper staff were employed. There were enough staff to keep patients safe.

The practice took a multi-disciplinary approach taken in identifying and following up on safeguarding concerns. Child protection plans were also reviewed to ensure vulnerable children and adults were kept safe. Risks to patients' health and social care needs were assessed, appropriately reviewed and well managed.

Are services effective?

Outstanding ☆

The practice is rated as outstanding for providing effective services.

The practice had effective systems in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.

Clinical outcomes for patients were consistently higher when compared with other similar services and the national average. This included: lower rates for emergency admissions, out of hours usage and attendance of Accident and emergency (A&E) services which were below local and national averages.

The practice worked in a proactive and robust way with other multi-disciplinary professionals to ensure the delivery of co-ordinated care. The discussions included the following key

Summary of findings

themes: regular monitoring of the patients' needs and advance care planning; assessment of mental capacity and do not resuscitate decisions; carer support (respite care or a suitable care package); control and management of symptoms; and the provision of anticipatory medication.

The admissions avoidance work had a focus on improving outcomes for patients at most risk of unplanned admissions to hospital and preventative care arrangements were in place. This ensured patients could continue being cared for in the community.

The practice had identified 4% of the patients at most risk which was above the contractual requirement of 2%. Robust systems were in place for care planning and on-going reviews of patient's individual health needs and medicines.

The practice had a multi-disciplinary focus to driving improvements and sharing innovations for end of life care arrangements including provision of anticipatory medicines within the CCG area. The practice took into account the needs of patients receiving palliative care and recognised that many of them wanted to receive the highest quality of care and support to enable them to die with dignity in their own home or care home. Effective systems were in place to ensure this happened.

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. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for providing caring services.

We observed a strong patient-centred culture and staff were committed to delivering compassionate care for all their patients. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. This included a proactive approach in care planning arrangements and multi-disciplinary working to address social isolation and emotional needs amongst its patient population. Information to help patients understand the services was available and easy to understand.

Feedback received from patients was consistently and strongly positive about the care and treatment they had received. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We

Summary of findings

also saw that staff treated patients with kindness and respect, and maintained confidentiality. Views of health care professionals and care home managers were also very positive and aligned with our findings.

Nationally reported data showed patients rated the practice higher than others for almost all aspects of care with most values over 90%. The national patient survey published in January 2015 showed the practice respondents found the GPs and nurses were good at treating them with care and concern, and involved them in decisions about their care. Reception staff were also described as being caring and helpful.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

The practice proactively reviewed the needs of its local population and designed and delivered services to meet these locally to avoid patients having to travel. The practice engaged well with the NHS England Area Team and CCG to drive and secure service improvements in patient care.

The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. This included a comprehensive and well embedded admission avoidance care planning process through effective and proactive multi-disciplinary working with other health and social care professionals.

Patients at most risk of hospital admission were identified, regularly reviewed and received coordinated care on discharge from hospital. Preventative and supportive care was delivered for older people, people with mental health needs and long term conditions to ensure they could be treated more effectively in the community.

The emergency admissions rate for adult experiencing poor mental health and people aged 65 and over was consistently below CCG average between 01 April 2012 and 31 March 2015.

The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). Patients told us it was easy to get an appointment and a named GP or a GP of choice, with continuity of care and urgent appointments were available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Outstanding 

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

The practice had a clear vision with quality and safety as its top priority. Staff were clear about their responsibilities and were highly motivated and committed to delivering well-led services. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

The practice had strong leadership in championing multi-disciplinary working to ensure patient centred care, improve patient experiences and outcomes. Feedback received from patients and allied health and social care professionals confirmed high standards of care were promoted and owned by staff.

There was a clear and consistent leadership structure and staff felt supported by management. There was an open, positive and supportive culture. Governance and performance management arrangements were proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning and had plans to merge with another practice.

There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice gathered feedback from patients, and it had a very active patient participation group (PPG). The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Robust systems were in place to identify and manage risks, and to ensure the service was well managed. The commitment to patient safety, learning and the development of staffs' skills was recognised as essential to ensuring high quality care.

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 the care of older people.

Fifteen per cent of the practice population comprised of patients over the age of 75 years. All these patients were offered an annual health check and had a named GP to ensure their care needs were being met. Nationally reported data showed that clinical outcomes for patients were good for conditions commonly found in older people. For example all patients on the osteoporosis register were receiving appropriate treatment and 94.6% of patients on the rheumatoid arthritis register had received a face to face review within the last 12 months.

The practice offered proactive and personalised care to meet the needs of older people. Staff knew that older people may also have long term conditions and may present in vulnerable circumstances. The practice provided an enhanced GP service to five care homes for older people, with one care home having a young disabled unit. This service included weekly visits by a designated GP to provide continuity of care.

Patients' care needs were regularly reviewed and their care plans updated. This was confirmed by three care home managers we spoke with. The community matron met with the care home staff on a quarterly basis as part of collaborative working and quality assurance. The practice was described as being responsive to residents in care homes although the timeliness of taking INR (monitoring the clotting time of the blood) blood tests needed improvement.

Home visits and telephone consultations were provided by GPs on a daily basis. The GPs also attended the local community hospital to manage patients on the rehabilitation ward, the elderly psychiatric ward and the day unit for physical and psychological care.

The practice team worked closely with other organisations such as social services, hospices and charities to maintain better care outcomes for patients. This included liaison with the various day centres and care agencies to support housebound patients. All staff had received relevant training on safeguarding vulnerable people, and knew how to recognise and respond to signs of abuse.

People with long term conditions

Outstanding ☆

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

Summary of findings

We found there was a holistic and pro-active approach to meeting patients' needs. Staff took pride in delivering excellent end of life care package with other multi-disciplinary professionals. Anticipatory medicines were kept in just in case boxes which were stored in the patient's home.

Clinical staff attended weekly multi-disciplinary meetings to discuss the management of patients with long-term conditions. The meetings provided a forum to review patients' needs and ensured they received coordinated and well managed care and treatment. The professionals commented positively about the range of skill mix within the team and how this promoted integrated working.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Nationally reported data showed that clinical outcomes for patients with long term conditions were mostly above national and local area average. This included conditions such as asthma, chronic kidney disease and diabetes. The practice offered advice and support for patients with long-term conditions; and aspired to motivate patients to take responsibility for their own health.

Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. The GPs liaised with consultant colleagues based at local hospitals to gain advice as well as specialist nurses regarding specific management such as the epilepsy nurses.

Families, children and young people

Outstanding ☆

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

We saw good examples of joint working with midwives, health visitors and school nurses. The health visitor was attached to the practice and met with the GP lead to discuss child protection concerns on a monthly basis and also attended the multi-disciplinary team meeting to update the team of all families of concern. This helped to ensure children were safe and protected from harm.

Nationally reported data showed children accounted for 17% of the practice population. 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 accident & emergency (A&E) attendances. A&E

admissions for children between zero and four years; as well as 17 to 18 were below the CCG and national averages; while the rates for children aged five to 17 was slightly above the CCG and national averages.

Immunisation rates were relatively high for all standard childhood immunisations with current figures averaging 95%. A flu campaign for pre -school children was also facilitated on specific Saturday mornings by the nurses and a GP. A young person's / sexual health clinic was held on a Monday evening from 4.00pm until 5.30pm and patients could book an appointment with the practice community matron or drop in.

Staff told us the practice had run this clinic for 18 years and services included information on sexual health and contraception. Teenage girls were also invited for health screening and their school leaving vaccinations. The practice had achieved 90% attendance for the human papilloma virus (HPV) programme. HPV vaccination protects against cervical cancer.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

A young people's page on the practice website listed useful information including student health, bullying and drugs. The community matron who was also a nurse prescriber therefore could attend to small children and mothers with minor illnesses as an alternative to seeing a GP.

The practice staff and the patient participation group (PPG) told us they had very good relationship with local schools in the area. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Feedback received from Healthwatch included the views of students captured during a citizenship class. The students said the appointment system was good and sometimes they could get a same day appointment if needed. They had mixed views about the GP attitude.

Working age people (including those recently retired and students)

Outstanding ☆

The provider is rated as outstanding for safe, effective, caring, responsive and well-led services. These ratings apply to everyone using the practice, including this population group.

Summary of findings

The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services including prescription requests and comprehensive information about support organisations.

Patients were able to book appointments around their working day by telephone or on line. They were also offered same day telephone consultations where appropriate. The practice offered extended opening hours aimed at patients with school, caring and / or work commitments. It was open until 8pm on a Monday and open at 7am on a Wednesday.

A full range of health promotion and screening that reflects the needs for this age group was promoted. This included a 24 hour blood pressure monitoring service, NHS health checks, travel vaccinations and smoking cessation.

Four patients we spoke with confirmed regular health checks were undertaken and this promoted early diagnosis of their long term health condition and empowered them to take better care of their health.

Performance data showed a high uptake for most health checks and health screening programmes and this was comparable and / or above CCG and national averages. Students could register as temporary residents or for contraception only service.

People whose circumstances may make them vulnerable

Outstanding ☆

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

The practice held a register of patients living in vulnerable circumstances. This included people with a learning disability; people receiving palliative care, carers and patients at risk of abuse. Patient feedback showed staff were caring, compassionate and took time to listen to patients.

Each patient had a named GP to provide continuity of care. Patients had same day access to a GP, community matron or nurse. Longer appointments and home visits were available when needed.

The practice staff were very much aware of the need to reduce the risk of social isolation for patients living in some remote areas of Bakewell. A multi-disciplinary approach was taken to address the needs of patient's whose circumstances may make them vulnerable.

We noted several examples of outstanding practice where a holistic and pro-active approach had resulted in positive outcomes for

individual patients. This included: integrated care to avoid unplanned admissions for patients at most risk; end of life care arrangements including provision of anticipatory medicines; personalised care plans and robust processes to keep patients safe.

The practice community matron and care coordinator liaised with hospital staff to communicate concerns and recommend a discharge package to ensure the patient's safety. Robust systems were in place to safeguard patients from abuse.

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. An alert system was used on a patient's record to ensure staff were aware of those vulnerable patients on the protection register.

The 2014/15 practice data showed staff had undertaken annual health checks for all 19 patients on the practice's learning disability register. Information was available to patients and carers signposting them to support groups and external agencies.

Tourists and scouts visiting the Bakewell area could easily register as temporary residents. This ensured they could access appropriate care and support when needed. The Clinical Commissioning Group confirmed the practice was very responsive to their care needs.

The practice had personalised care plans in place for 4% of patients at most risk of hospital admission, which is above the contractual minimum of 2%. Additionally, most of these patients had do not resuscitate cardio pulmonary resuscitation (DNACPR documentation) in place which was shared with Derby Health United, the out of hours service.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

The practice had 29 patients on its mental health register and 22 patients were eligible / had a care plan in place. Nationally reported data showed that outcomes in this group were above the local and national averages in 2014/15. For example:

- 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. This was 6.3% above the CCG average and 14.1% above the national average.

Summary of findings

- At the time of our inspection, 65% of people experiencing poor mental health had received a review of their care plan or annual physical health check.
- The practice rate for annually reviewing patients with dementia was 91.7% in 2014/15. This was 4.9% above the CCG average and 7.9% above the national average.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. This included the community psychiatric nurse, the mental health crisis team and care home staff.

Patients experiencing poor mental health had access to counselling services at a local hospital and various support groups and voluntary organisations. Effective systems were in place to follow up patients who had attended accident and emergency (A&E) and may have been experiencing poor mental health.

The practice carried out advance care planning for patients with dementia. We received positive feedback from three care homes in respect of suitable arrangements being in place to facilitate regular reviews of care plans, patients mental capacity and do not resuscitate decisions.

The practice also provided GP cover at two of the wards at Newholme hospital one of which provides care for elderly patients experiencing poor mental. The practice was signed up to the directed enhanced service to facilitate timely diagnosis and support for patients with dementia. The practice was signed up as a dementia friendly practice to promote raised awareness of dementia patients amongst all practice staff.

Summary of findings

What people who use the service say

Patients expressed a high level of satisfaction about the care and services they received and this was supported by the national patient survey results published in January 2015 and the practice's own survey.

Most patients told us the delivery of care was excellent and the staff team had a genuine interest in their wellbeing. They confirmed their care needs were assessed and regularly reviewed. They told us they were able to access care and treatment when they needed it.

Most patients described their experience of making an appointment as good, with urgent appointments usually available the same day. A few people commented that improvements were required to ensure ease of access to GP of choice to promote continuity of care.

They found the premises accessible and clean. Patients told us that they were treated with dignity and respect, and described the staff as friendly, helpful and caring. They also said that they felt listened to, and able to raise any concerns with staff if they were unhappy with their care or treatment at the service.

We reviewed patient feedback shared by Healthwatch. The comments covered different population groups and were made between September 2013 to September 2014. The comments were largely positive specifically in relation to information and support available for carers and on the practice website, accessibility of appointments and staff being helpful and caring. This also aligned with the feedback noted in 15 CQC comment cards we received.

We received written feedback from three care homes and spoke with two care home managers where patients were registered with the practice. They were mostly complimentary about the services provided, and said the practice staff were responsive to patients' needs. They also felt that staff were approachable and the practice was well led.

We spoke with four patient participation group (PPG) members who felt the practice was well run and staff delivered an excellent service and a good experience for people's care. The needs of the older members were specifically noted as being well looked after. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Areas for improvement

Action the service SHOULD take to improve

- Ensure clinical audits in respect of contraceptive implants and minor surgery are undertaken regularly and so in line with their registration and National Institute for Health and Care Excellence guidance.

Outstanding practice

- Patients were protected by a strong safety focus and robust systems were in place to safeguard patients from abuse. For example, the practice had used the Manchester Patient Safety Framework (MaPSaF) as a basis for developing their error reporting protocol. This had promoted a genuinely open culture in which all safety concerns were highly valued and integral to learning and improvement. The MaPSaF helps healthcare organisations to reflect on their progress in developing a mature safety culture.
- The practice had an established and embedded process for multi-disciplinary working to deliver integrated care that was centred around the patients'

needs and experience. As a result, robust systems were in place for effective care planning and on-going reviews of patient's individual health needs and medicines.

- Outcomes for patients were consistently higher when compared with other similar services and the national average. his included: lower rates for emergency admissions, out of hours usage and attendance of Accident and emergency (A&E) services which were below local and national averages.
- The admissions avoidance work had a strong focus on improving outcomes for patients at most risk of unplanned admissions to hospital and preventative care arrangements were in place. This ensured patients could continue being cared for in the community. The practice had identified 4% of the patients at most risk which was above the contractual requirement of 2%.
- One of the GP partners had led innovations across the CCG area to drive improvements in respect of end of life care. This showed the GP had a strong commitment to improving the outcomes for patients in the wider locality. The practice showed a high level of commitment to the needs of patients receiving palliative care and recognised that many of them wanted to receive the highest quality of care and support to enable them to die with dignity in their own home or care home. Effective and robust systems were in place to ensure they received their end of life care in line with their expressed preferences.

Bakewell Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead Inspector. The team included a second CQC inspector, a GP, a practice manager and an expert by experience.

Background to Bakewell Medical Centre

Bakewell Medical Centre is a semi-rural practice with an ethos of providing high quality and continuity of care. It is a partnership between three GPs providing primary medical services to about 6000 patients. It is a dispensing practice and 40% of the practice population access this service.

The practice is registered with the CQC to provide: diagnostic and screening procedures; treatment of disease, disorder or injury; surgical procedures; maternity and midwifery; and family planning. The regulated activities are provided from a single site; The Medical Centre, Butts road, Bakewell, Derbyshire, DE45 1ED.

The GP partners are supported by two associate GPs and two GP registrars. The nursing team include a community matron (employed by the practice), senior practice nurse, practice nurse, two health care assistants and one health care assistant / care coordinator. The practice is a training practice for GP registrars and medical students.

The administrative team include a practice manager, assistant practice manager, clinical audit manager, dispensary manager and 11 members of staff who have varied roles in undertaking reception, secretarial and dispensing activities. Community staff based at the surgery includes the health visitor, midwife, nursery nurse, community nurse and health care assistant.

The practice holds a General Medical Services (GMS) contract to deliver essential primary care services. The practice offers a full range of community services recognising the distance from the acute hospitals which serve the local community. For example they run weekly clinics related to antenatal care, babies, childhood vaccinations, long term conditions, minor surgery and teenage sexual health.

The practice is also contracted to provide a number of enhanced services, which aim to provide patients with greater access to care and treatment on site. These include admissions avoidance, extended hours and learning disabilities checks.

The practice does not provide out-of-hours services to its registered patients. This service is provided by Derbyshire Health United and contact information is available on the practice answer phone and practice website

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. This included NHS England, North Derbyshire Clinical Commissioning Group and Healthwatch. We carried out an announced visit on 12 May 2015.

During our visit we spoke with a range of staff including: three GPs, a GP registrar, the community matron, two practice nurses, two district nurses, the practice manager, a care coordinator, dispensing manager and four administrative staff.

We spoke with nine patients who used the service. This included four members of the practice's patient participation group (PPG). We also received written patient feedback from one PPG member. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

We also spoke with two care home managers and received written feedback from three local care homes receiving a GP service from the practice. We did this to confirm that the care and services met the needs of patients who were older people with long term conditions, patients experiencing poor mental health and / or dementia.

We observed how people were being cared for, checked the premises and reviewed a range of the practice's records. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Outstanding ☆

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. We found the practice had taken a proactive approach in prioritising patient safety within the last 12 months. This included reviewing the processes in place for identifying, reporting and managing risks.

The practice had used the Manchester Patient Safety Framework (MaPSaF) as a basis for developing the practice's error reporting protocol and facilitating "a team based self-reflection and educational exercise on improving patient safety culture".

The MaPSaF helps healthcare organisations to reflect on their progress in developing a mature safety culture. The impact of using this tool included improvements being made to the way safety concerns, near misses and complaints were reported, logged, investigated, actioned and reviewed.

Staff we spoke with confirmed improvement work had been done to ensure they felt safe to report errors, significant events and incidents; and that reporting forms were easy to access and use. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff completed incident forms by hand or online and then submitted them to the practice manager. The manager showed us the system used to manage and monitor incidents.

We tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, following an incident where the wrong medication was removed from a patient's dosette box, the practice reviewed its standard operating procedures so that any changes to dosette boxes were checked by two staff members and recorded. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

Learning and improvement from safety incidents

The practice leadership shared a strong view that safety concerns were of significant value and integral to staff learning and improving the service. Staff told us team learning was encouraged through open discussions about the safety concern, the investigation outcomes and ways of reducing the incidents were considered.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The practice had a system in place for reporting, recording and monitoring significant events and accidents. We reviewed records of significant events that had occurred during the last two years and saw this system was followed in practice.

Meeting minutes that we looked at showed significant events were discussed at practice and multi-disciplinary meetings and there was evidence of shared learning with relevant staff. For example, the practice introduced a system to highlight any blood testing appointments that had been missed by patients following a significant event. The event related to a delayed diagnosis of pulmonary embolism (a blood clot in the artery that transports blood to the lungs).

National patient safety alerts were disseminated by the practice manager to all staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had embedded systems in place to keep patients safe. The practice had dedicated GPs as leads for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. The lead safeguarding GPs were aware of the practice's vulnerable children and adults; and records demonstrated good liaison with partner agencies such as the police and social services.

This also included provision of information, reports and/or attendance at meetings. For example, the multi-agency risk assessment conference where high risk domestic abuse cases were discussed; case conferences chaired by social services and vulnerable adults management meetings where patients who have capacity chose to make unwise decisions and live in situations of high risk.

Outstanding ☆

Are services safe?

We observed the practice's weekly multi-disciplinary meeting and noted that early identification of safeguarding concerns was prioritised, discussed with professionals present and a protection plan was agreed and / or reviewed. The protection plan included referral to social services, housing support or voluntary agencies and monitoring of the patient's health and social care needs.

For example, the social worker and health visitor present fedback to the team the outcomes of their parenting assessments and police investigations, the child protection plan and safety netting in place to minimise the risks of further abuse. This ensured the practice's clinician's had up to date information on patients in the event they needed GP and nursing care. A community psychiatric nurse from the adults mental health services also attended the practice meeting and discussed any safeguarding concerns.

There was clear evidence from staff discussions and notes documented in patient records of proactive monitoring of safeguarding concerns to prevent situations getting worse. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

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

All staff we spoke with were aware who the GP safeguarding leads were and who to speak with in the practice if they had a safeguarding concern. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff had been trained to be a chaperone. Reception staff who had been trained in chaperone duties would act as a chaperone if nursing staff were not available.

Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice had systems to manage and review risks to children, young people and vulnerable adults. This included:

- Identification and follow up of children, young people and families living in disadvantaged circumstances
- Systems for identifying children and young people with a high number of A&E attendances
- Follow up of children who persistently failed to attend appointments for childhood immunisations and
- Systems to highlight vulnerable patients including older people and people living in isolation.

Medicines management

The practice had a clear policy for ensuring that medicines were kept at the required temperatures. This included guidance on safe vaccine storage and handling to ensure they were kept at the recommended temperature. Records reviewed showed staff followed the policy. We checked medicines and vaccines stored in the treatment rooms and refrigerators and found they were stored securely and were only accessible to authorised staff.

Processes were in place to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. All the medicines we checked were within their expiry dates. The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance.

We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was

qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

The practice offered a dispensary service to about 40% (2,400) of its practice population. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

We saw that three monthly audits of dispensary activities were being completed and arrangements were in place for incident reporting, reviewing of concerns and shared learning. This demonstrated that the quality of service provision was regularly assessed and monitored.

One of the GP partners had accountability for the dispensary quality and worked closely with the dispensing staff and community matron to improve outcomes for patients. The community matron also supported staff in checking scripts and highlighting any potential errors or queries. We noted dispensing errors had reduced within the last 12 months as a result of changes to the error reporting system and a commitment by staff to ensure a safe track record.

Records showed that all staff involved in the dispensing process had received appropriate training and their competence was checked regularly. Four staff members had achieved level two national vocational qualifications (NVQ) in dispensary training and three other staff were undertaking the programme.

Standard operating procedures (SOPs) were available for dispensing activities undertaken and these were reviewed and updated at least annually. This included ordering, collecting, prescribing and destroying out of date medicines.

Dispensing staff were aware prescriptions should be signed by a GP before being dispensed. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw that this process was working in practice.

The practice had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required. Information on the dispensary services was available to patients including how to obtain medicines urgently and opening times.

The results of the practice's 2014 dispensary service survey showed most of the 51 patients felt the practice offered an excellent service in areas such as: the quality of advice given by the dispensers (82%), ease of ordering prescriptions (76%), and the time taken between ordering and collecting repeat prescriptions (78%).

The community matron and the Clinical Commission Group (CCG) medicines management team also worked in partnership with care home staff to review the residents' medicines on a regular basis. The community matron told us this initiative promoted good working relationships with care home staff and ensured positive outcomes for patients.

The practice had reviewed all care home residents at the time of our inspection with savings made on nutritional supplements. Feedback received from three care homes confirmed this had happened. The overall feedback was that good systems were in place for the management of patients' medicines.

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

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice had arranged for a controlled drug audit to be undertaken by the NHS North Midlands controlled drug support officer to ensure they were complying with best practice. The report showed the practice had implemented most of the recommendations and action plans were in place to complete other recommendations.

Are services safe?

There was a system in place for reviewing repeat medicines for patients with who had several prescribed. Practice data showed 94% of patients on four or more medications had received a medication review in 2014/15; and 82% of patients on repeat mediation had received a review.

Staff from one care home felt improvements were still required to the timeliness and process of taking blood tests used to identify the correct dose of warfarin ;but our inspection of the management of high risk medicines indicated there was regular monitoring in line with national guidance. We identified appropriate action was taken based on these results.

Patient education events were being planned for every last Wednesday of the month between 11am and 2pm to enable patients to discuss medicines and their effects, for example night sedation.

Cleanliness and infection control

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

The practice had a nurse lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates.

Records reviewed showed the practice manager and community matron had carried out the most recent audit on 15 April 2015 and most of the identified improvements had been completed. Minutes of practice meetings showed that the findings of the audits and risk assessments were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Staff were also aware of the procedures to follow in the event of a needle stick injury, blood and other body fluid spillages.

Notices about hand hygiene techniques were displayed in most of the staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. A hand washing and hygiene protocol was also in place.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had all the necessary equipment they needed to meet the needs of patients accessing the service. This included measuring devices for blood pressure, pulse and lung function (spirometer), which enabled clinical staff to carry out diagnostic examinations, assessments and treatments. We saw records to confirm that a schedule of testing was in place to ensure all equipment was safe for use and properly maintained.

For example, all portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of 21 April 2015. We saw evidence of calibration of relevant equipment; for example weighing scales, height measurers, otoscopes (an instrument for examining the ear) and fridge thermometers. New equipment had been purchased to replace equipment that had failed the calibration test.

Staffing and recruitment

The four staff records we looked at contained evidence to demonstrate that appropriate recruitment checks had been undertaken prior to employment. This included: proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement

in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. All appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and resuscitation equipment. A dedicated staff member was allocated protected time each week to update the practice's risk assessments and these were shared with the team.

The practice risk log included hazards such as slips, trips and falls, work related stress, manual handling, and lone working. Each identified hazard and associated risks were assessed and rated, and mitigating actions recorded to reduce and manage the risk. We saw that risks and risk assessments were reviewed and discussed at the practice team meetings.

The practice had a health and safety policy (reviewed every two years) which set out the arrangements in place to maintain a healthy and safe working environment. This included health and safety training and actions taken by the practice to control substances that are hazardous to the health of staff (COSHH). Health and safety information was also displayed for staff to see and there was an identified health and safety representative.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: there were emergency processes in place for patients with long-term conditions and staff gave us examples of referrals made for patients whose health deteriorated suddenly. This included responding to patients experiencing a mental health crisis and supporting them to access emergency care and treatment.

The practice monitored repeat prescribing for people experiencing poor mental health. Procedures for dealing with emergencies were available for administrative staff and these included requests for emergency appointments and management of sudden chest pains in adults. Flowcharts were located on the staff noticeboard for reference.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all practice staff had received training in cardio pulmonary resuscitation, basic life support and anaphylaxis.

Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). All the staff we spoke with knew the location of this equipment and records confirmed that it was checked monthly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (allergic reaction) and hypoglycaemia (low blood glucose levels). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included adverse weather (snow and flooding) which affects the local area, loss of IT and utilities such as water and power failure. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed regular fire drills were practised and staff were up to date with fire training. Fire drills were undertaken every six months, the most recent in November 2014.

A schedule was in place for testing the smoke alarm, security and emergency lighting and fire extinguishers.

Outstanding ☆

Are services safe?

Risks associated with service and staffing changes (both planned and unplanned) were included on the practice risk log. We saw an example of this and the mitigating actions that had been put in place to manage this.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the patient electronic system hyperlinks and / or website by each individual staff. We saw some records of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were identified and required actions agreed.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective.

For example, patients with diabetes had regular health checks and were referred to other services when required. Ninety six percent (96%) of patients with diabetes, on the diabetes register, had a record of a foot examination and risk classification. This was 6.7% above CCG average and 7.7 % above national average. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they led in specialist clinical areas such as mental health, education planning, minor surgery and care of long term conditions such as diabetes, heart disease and asthma. The practice nurses supported this work, which allowed the practice to focus on specific conditions.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two week by the practice community matron or GP according to need.

National data showed that the practice was significantly below local and national averages for referral rates to secondary care and other community care services for most conditions, between 01 April 2012 and 31 March 2015. This included referrals for general surgery, ophthalmology, cardiology and paediatrics. All the GPs we spoke with used national standards for the referral; for example of patients with suspected cancers were referred and seen within two weeks.

National cancer commissioning data for 2014 showed 41.2 % of new cancer cases were treated; this was below the CCG average of 48.5 % and national average of 48.8% We saw records to confirm that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. The senior GP partner attributed this to the peer review system in place for doctors to review each other's referral before they are made externally.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, and culture as appropriate.

Management, monitoring and improving outcomes for people

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

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice had a system in place for completing clinical audit cycles. The practice showed us five clinical audits that had been completed within the last two years. Following each clinical audit, changes to treatment or care were made where needed.

Two of the five audits had been repeated to ensure outcomes for patients had improved. For example, an audit of the treatment of acne was initially undertaken in December 2013 to review the clinicians' practice in recording their assessments of acne; comparing this against the agreed acne care pathway.

The first audit demonstrated that five out of six criterion of the acne pathway had not been met. The information was shared with GPs and a review of patient records and / or health needs was undertaken. A follow up audit was completed nine months later which evidenced improved recording of the type of acne, location, severity and compliance with prescribed medicines.

For example, 90% of patient records reviewed showed the extent of acne recorded compared to the initial findings of 55%. This ensured the clinicians were following best clinical practice in their assessment and recording of patient's health needs and seeking to improve patient outcomes.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

For example, we saw an audit regarding the prescribing and monitoring of controlled drugs and orlistat (a medicine which can help a person lose weight if they are obese or overweight). Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. The practice achieved a total of 99.7% QOF points in 2014/15, which was above the national average of 93.5%. Specifically, 100% of the points were achieved in all 20 clinical areas which was 3% above CCG average and 7% above national average.

Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average. The practice had achieved 100% QOF points which was 1.7% above CCG average and 6.6% above national average
- Performance for mental health related indicators was better than the national average. The practice had achieved 100% points which was 2.3% above CCG average and 9.6% above national average.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The senior partner told us the effective systems in place for medicines management was a contributing factor to low hospital admissions as patients had the right medicines at the right time. The practice had completed 264 dispensing reviews of the use of medications (DRUMS) between 01 April 2014 and 31 March 2015. DRUMs are face to face

reviews which include checking the patient's understanding and management of their medicines; as well as their ability to order and receive medicines for example.

The GPs felt DRUMS allowed patients an opportunity to ask questions about their medicines and improved the overall clinical outcomes for patients. This included encouraging the safe use and correct administration of medicines; addressing any side effects caused by the medicines and ensuring patients were taking medicines they needed.

One GP told us DRUMS were invaluable in terms of building up relationships with patients, educating patients and determining interactions which perhaps a GP did not have time to discuss in a 10 minute review. The practice staff were looking to improve medicines maximisation further by holding patient education events on the last Wednesday of the month to enable patients to discuss medicines and their effects, for example night sedation.

The practice made use of the principles underpinning the gold standards framework for end of life care. It had a palliative care register and had weekly multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example frail elderly and those with long term and / or experiencing poor mental health.

Structured annual reviews were also undertaken for people with long term conditions, for example diabetes, chronic obstructive pulmonary disease (COPD) and heart failure. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice had a training and development policy in place. We saw that staff were up to date with attending mandatory courses identified by the practice such as annual basic life support. We noted a good skill mix among the GPs and nursing team with the community matron having additional diplomas in sexual and reproductive medicine, and GPs with diplomas in palliative care.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Those with extended roles for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

We found the practice was outstanding in ensuring that services were tailored to meet the needs of individual patients. In particular, staff were actively involved in multi-disciplinary working and delivery of care in a way that ensured flexibility, choice and continuity of care.

We observed the practice's weekly multi-disciplinary team (MDT) meeting as part of our inspection. Thirteen professionals were in attendance including GPs, a practice employed community matron, nurses, health visitor, social

worker and a community psychiatric nurse. We found the group had a strong ethos of shared care and focused on patients at risk to enable the planning of proactive care amongst the professionals.

For example, the practice had identified 222 patients for their admissions avoidance register and 209 patients had agreed care plans in place. This represented 4% of the practice adult population (18 years and over) at risk of unplanned hospital admission and was above the recommended contractual agreement of 2%.

The professionals reviewed hospital admissions and A&E attendances to assess if they were appropriate and the reasons for accessing out of hours services. Decisions about each patient's care plan were documented in a shared care record during the meeting. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Preventative care was also discussed to help prevent the need for any further hospital admissions or deterioration in health. For example, referrals to secondary care for dementia screening, mental health crisis team, cardiology and urology.

Referrals for the rehabilitation of patients who had lost their independence as a result of falls or an exacerbation of a long term condition such as heart disease and chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections were also made. Each patient had a named accountable GP and same day telephone access was offered to ensure the effective management of their health needs.

Our observations and discussions with staff showed different skills were brought together and care was organised around the patient. This ensured better use of resources and a coordinated approach to the delivery of care, seven days a week. The practice employed a community matron who had a caseload of about 60 patients at the time of inspection and we saw examples of effective case management of patients which helped prevent hospital admissions.

Examples included short term intervention such as requesting emergency care packages for patients recently discharged from hospital and on-going monitoring of their health needs in the community. Staff also discussed education and support for patients to self-manage their long term conditions for example diabetes and asthma.

The North Derbyshire CCG locality data for periods between November 2011 and October 2014 confirmed positive outcomes were achieved for patients. For example, the practice had the lowest hospital admission rates and the second lowest attendance of A&E in the CCG area. The values were all below the national average despite having an increased older population who may be more at risk of developing multiple health needs and being in a location some distance from the nearest acute hospital.

The practice staff felt this was a direct result of their robust systems to deliver integrated community care and case management. Feedback from patients and other health and social care professionals showed providing integrated care closer to the patients' homes ensured patients accessed care and treatment in a timely way and reduced the burden on hospital services.

The practice also participated in the multi-agency Dales Integrated Care Excellence (DICE) forum group which is a sharing and learning meeting held monthly over lunchtime. DICE aims to provide a community based service where professionals from health, social care and the voluntary sector can jointly deliver care that ensures patients receive the right treatment and support, when needed and in the right place.

For example, the community matron talked us through an example where the practice had difficulty in arranging a care package to prevent a hospital admission. The case was discussed at the forum and the community matron was made aware of the services they could have contacted. The community matron told us one of the greatest assets of the forum was learning more about the work of others and resources available for patients. One of the GP partners had been involved in the set-up of DICE evidencing a commitment to improving services across the CCG area.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw that the policy for actioning hospital

communications was working well in this respect. The practice undertook a weekly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups medical checks were missed.

The practice's care coordinator had been in post since February 2015 and they were supported by the community matron. Their role included contacting patients within 72 hours of hospital discharge to ensure delivery of coordinated care and that patients had all the equipment and medicines required.

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications.

Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All the staff we spoke with understood their roles and felt the system in place worked well.

Information sharing

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

Electronic systems were also in place for making referrals, and through the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff reported that this system was easy to use.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary care record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and this was fully operational at the time of our inspection. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

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

We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. For example, 99% of patients had up to date summaries and 93% of new notes had been summarised as at 31 March 2015.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Reception staff we spoke with demonstrated awareness of consent and records reviewed showed some staff had received related training. However, some non-clinical staff were not fully aware of the MCA 2005 and its requirements.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing and a review date was noted. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and consent decisions about the

place of care, type of care and information sharing with outside services. The 2014/15 practice data showed staff had undertaken annual health checks for all 19 patients on the practice's learning disability register.

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

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was obtained with a record of the relevant risks, benefits and complications of the procedure. The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice leadership were aware of the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

New patients registering with the practice were offered a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to its patients aged 40 to 75 years. Practice data showed 491 invites had been sent out in 2014/15 and 238 patients had received a check. This represented an uptake of 48.5%. We were told that patients were followed up by a GP if a patient had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were overweight and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 81.81%, which was comparable to the national average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The 2014 Public Health England cancer commissioning data showed the practice's performance for national mammography and bowel cancer screening in the area were mostly in line with the average for the CCG.

For example,

- 65.1% of patients aged 60 to 69 had been screened for bowel cancer in the last 30 months which was slightly above the CCG average of 63.1% and national average of 58.3%
- 76.2% of females aged 50 to 70 had been screened for breast cancer in the last 36 months which was in line with 77% of the CCG average and above the national average of 72.2%.
- 48.6% of new cancer cases had been treated (% of which are two week referrals) and this which was in line with the CCG average of 48.5% and national average of 48.8%

A similar mechanism of following up patients who did not attend was also used for these screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example childhood immunisation rates for the vaccinations given to:

- under twos ranged from 70% to 100% comparable to the CCG average of 75.7% to 100%; and
- five year olds from 87% to 100% comparable to the CCG average of between 95.4% to 99.1%

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- Flu vaccination rates for patients aged 65 and over was 82.18% which was above the national average of 73.24%

The community matron facilitated a weekly teenage clinic where young person's dropped in to discuss any health concerns including sexual health and contraception. The practice had achieved an uptake of 90% for the human papilloma virus (HPV) programme for teenage girls. All girls aged 12 to 13 were offered HPV as part of the NHS childhood vaccination programme. The vaccine protects against cervical cancer This service was proactively advertised local colleges and the practice website.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We found there was a strong person-centred culture and staff were highly motivated to offer care that was kind and promoted people's dignity. This was confirmed by feedback received from patients; interviews with practice staff, allied health and social care professionals; and discussions held during the practice's weekly multi-disciplinary meeting. We observed staff to be caring and understanding, while remaining respectful and professional.

Eight out of nine patients we spoke with expressed high levels of satisfaction with the care they had received. Common themes from comments included; staff looking after patients, treating them as individuals, being friendly, offering brilliant care and a very good service.

Patients also completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 16 completed cards and all of them were complimentary of the care and support received. Most patients told us the practice offered an excellent service and that staff were efficient, approachable and considerate. They commented staff treated them with dignity and respect.

We reviewed the most recent data available for the practice on patient satisfaction. This included results published in January 2015 from the national patient survey, the practice's compliments book and the family and friends test results.

The evidence from all these sources showed most of the patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice had been awarded the bronze dignity award as part of a campaign aimed at putting dignity and respect at the heart of services that care for people.

The data from the January 2015 national patient survey results showed the practice was above the CCG and national averages for most of its satisfaction scores on consultations with GPs and nurses. For example, out of 128 responses received;

- 95% described their overall experience of this surgery as good compared to the CCG local average of 88% and national average of 85%.
- 95% said the GPs were good at listening to them compared to the CCG local average of 92% and the national average of 89%.
- 94% of respondents said the GP gave them enough time during consultations compared to the CCG local average of 90% and the national average of 87%.

Higher values were also achieved for nurses and reception staff;

- 95% said the nurses were good at listening to them compared to the CCG local average of 92% and the national average of 91%.
- 98% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG local average of 93% and the national average of 92%.
- 91% found the receptionists at this surgery helpful compared to the CCG local average of 88% and the national average of 87%.

Feedback received from five external health and social care professionals was also strongly positive in respect of the care provided to patients. For example, staff were described as treating older people, people in vulnerable circumstances and those receiving end of life care in a sensitive and empathic manner in the delivery of their care.

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

We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. This was in line with the practice's objective of ensuring that, "the patient experience remains positive, enjoying a safe environment with privacy and dignity being respected at all times".

Due to the open layout of the reception desk, we found there was a potential for patients to overhear confidential information when queuing to speak with the receptionist; and two patients confirmed this had happened when they had attended. This was highlighted to the practice leadership who were already aware of this risk and had reviewed options to address this.

We saw that patients had access to a private room to discuss confidential matters, and only one patient was

encouraged to approach the reception desk at a given time. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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

Most staff had also received training in conflict resolution and customer care to improve their skills in communication, listening and resolving patient concerns. There was a clearly visible notice in the patient reception area and practice website stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

An outstanding feature of the practice was the proactive approach in ensuring personalised care, treatment and support through coordinated assessment, care planning and delivery. For example, the four care plans we reviewed showed evidence of patient involvement in agreeing these and included: each patient's assessed needs, their preferences, how care would be delivered and consent about do not resuscitate decisions.

Discussions with practice staff and our observations during the practice's multi-disciplinary meeting showed there was a shared ownership in the planning and delivery of care plans by all professionals involved. This included GPs, practice nurses, a community matron, a social worker, district nurses and a health visitor for example. This ensured patients received a seamless and integrated service.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, the January 2015 national patient survey results showed:

- 90% said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG local average of 86% and the national average of 82%.
- 92% of practice respondents felt the GP was good at explaining treatment and results compared to the CCG local average of 90% and the national average of 86%.

Higher values were also achieved for the nurses with;

- 90% of the practice respondents stating the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG local average of 86% and the national average of 85%.
- 94% of practice respondents felt the nurse was good at explaining treatment and results compared to the CCG local average of 92% and the national average of 90%.

All of the nine patients we spoke with told us their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Translation services were available to ensure people who did not have English as a first language were involved in decisions about their care.

Most of the patients also told us they felt listened to and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Patient feedback and our observations showed children and young people were treated in an age-appropriate way and were recognised as individuals with their preferences considered.

Feedback received from three care home managers confirmed the GPs and community matron were actively involved in reviewing the residents care plans to ensure their current health needs and service delivery were reflected. They also told us care planning discussions centred on the patient and involved care home staff and their next of kin where appropriate. This ensured each patient was valued as an individual and empowered to be a partner in their care.

The practice's QOF data for 2013/14 and 2014/2015 showed high values had been consistently achieved in respect of the completion of care plans for the population groups we inspected. For example, 100% of patients with schizophrenia, bipolar and affective disorder and other psychoses had a comprehensive agreed care plan

documents in the record in the preceding 12 months. Ninety-two per cent of patients diagnosed with dementia had been reviewed in a face to face review in the preceding 12 months.

Two hundred and nine out of 222 patients on the admissions avoidance register had care plans in place. This was representative of 4% of the patients on the practice's admission avoidance register and was above the contractual requirement of 2%.

Mitigating actions for managing identified risks such as hospital admission due to ill-health were also recorded in care plans to ensure patients received safe care. These care plans were also shared with the out of hours service (Derbyshire Health United) to ensure the needs of patients would continue to be met when the GP practice was closed or in the event of an emergency.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example;

- 93% said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.
- 98% had confidence and trust in the last GP they saw or spoke to compared to the CCG average of 97% and the national average of 95%.

Higher values were also achieved for the nurses with;

- 96% patients stating the last nurse they saw or spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 90%.
- 99% had confidence and trust in the nurse compared to the CCG and national averages of 97%.

The comment cards we received and most patients we spoke with highlighted that staff responded compassionately when they needed help and provided support when required. This included providing information on a range of support services to help patients manage with their social and health care needs.

For example, patients had weekly access to the citizens advice bureau (CAB) service which was held within the practice. CAB provide free, independent and confidential advice on matters related to benefits, debt and housing.

Some patients also gave specific examples of the support provided to them and their families following diagnosis of a long term health condition and the management of their mental health needs

Organisations such as Sight Support Derbyshire (a charity that is dedicated to improving the lives of people with sight loss) attended the practice and provided information and advice to patients. Notices in the patient reception area and practice website also told patients how to access a number of support groups and organisations.

Discussions held during the practice's multi-disciplinary meeting demonstrated that all professionals were proactive in supporting population groups such as older people, people experiencing poor mental health and families at risk of isolation to receive both practical and emotional support when needed.

This was particularly important given the practice was located in a semi rural area in the north of Derbyshire Dales where some of its practice population live in remote and dispersed locations. In addition, people aged 65 and over accounted for about 28% of the practice population; which was higher than the CCG value of 21.3% and national value of 17.2 %.

The practice maintained a "supportive care register" of which 150 patients were listed on the day of our inspection. This included patients: at risk of social isolation; in need of palliative care and support; those receiving care packages via social services; the elderly and / or frail; and patients with informal carers and / or living in long term accommodation such as care homes. These arrangements were reviewed and discussed during the multi-disciplinary we observed.

The practice assessed people with long-term conditions or anxiety and depression. Referrals were made for counselling and cognitive behaviour therapy (CBT) where appropriate. These services were offered from the practice, usually on a Monday morning and Wednesday afternoon to avoid patients having to travel to receive the support they needed.

The practice's computer system alerted GPs if a patient was a carer. We were shown the written information available for carers to ensure they understood the various avenues of

support available to them. The staff we spoke with demonstrated awareness of the support needs of young carers and the need to refer carers for respite through the social services.

The practice had signed up to the dementia friends programme run by Alzheimer's society to enable staff to be mindful of the needs of patients living with dementia. The national programme is an initiative to change people's perception of dementia and aims to transform the way the people think, talks and acts about the condition.

Staff told us that if families had experienced a bereavement, their usual GP or community matron contacted them and a bereavement pack was also sent out. This pack included a "with deepest sympathy" card and a booklet on bereavement with detailed information on help, advice and practical support such as how to arrange for a death certificate and a funeral, liaison with the coroners office, and government agencies to contact. The packs also included information on support services such as contact details for compassionate friends for bereaved parents, child death helpline and counselling services.

Calls to patients were either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patient comments in the practice's complimentary book and thank you cards confirmed they had received this type of support with bereavement and had found it helpful.

The practice was also involved in charity work which included: giving monetary donations, sending unused medicines as aid to charities / African countries and donating shredded paper for bedding use in animal orphanages.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly and proactively with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw records where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice took a proactive approach to the needs of patients receiving palliative care and recognised that many of them wanted to receive the highest quality of care and support to enable them to die with dignity in their own home or care home. The practice had succeeded in delivering this vision and had the highest number of home deaths within the CCG area for patients at the end of their life.

We found the practice participated in multi-disciplinary work with other health professionals to empower patient's in choosing their preferred end of life care so as to experience a good death. The community matron we spoke with gave examples of after death analysis that had been undertaken to evaluate if the patient's desired outcome of a home death had been achieved and any learning for staff. This demonstrated to us an embedded culture of commitment to continuous improvement.

One of the GP partners was the lead for end of life care in North Derbyshire CCG and a Macmillan GP advisor for the East Midlands. They spoke passionately about their role and the positive outcomes achieved for patients as a result of the practice's integrated work in end of life care.

Records reviewed and feedback from staff and patients confirmed the positive impact of the GP's strategic role in prioritising: the delivery of high quality end of life care; a positive experience for patients and their families in accessing health and social care services; as well promoting best practice within the practice and across the whole CCG area.

Feedback from three care homes receiving a GP service from the practice and a review of statutory notifications submitted to the Care Quality Commission showed patients had appropriate anticipatory medicines at the time of their death.

These medicines were administered by a GP or nurse to enable prompt symptom relief when a patient experienced distressing symptoms. The anticipatory medicines were kept in a "just in case box" at the patient's home or care home and were reviewed by the clinician who visited the patient as they included high risk medicines such as morphine, used to control pain. We were a shown an example of the box, and we were told that a fridge magnet alerting professionals to were the box was kept would be available in the patient's home.

At the time of our inspection there were 34 patients on the palliative care register. The practice had an alert system to highlight these patients and those with a diagnosis of cancer so as to ensure they were offered same day access to the GP and / or nurse when they rang for an appointment. The practice staff told us improving patient access and communication with other agencies ensured continuity of care for patients and reduced hospital admissions.

We found the practice had ensured all 34 patients on the palliative care register had right care plans in place which were shared with the out of hour's service. RightCare is a scheme which was designed by Derbyshire Health United (out of hour's service) clinicians to ensure that seamless patient care takes place out of hours, when GP practices are closed. The scheme helps to prevent unnecessary admissions to hospital and attendance at Accident and Emergency (A&E), and allows patients to access the most appropriate healthcare and advice quickly.

The practice had one of the lowest patient usage of out of hour's services within the CCG area. For example, the total number of calls to DHU from 39 practices using in one year were 57035. The average calls per practice were 1462 and the practice's actual number of calls was 1159.

The practice was in a semi-rural location some distance from the nearest acute hospital so the practice hosted a variety of clinics for the different population groups to enable them to access services locally. For example, young people could access health and sexual advice including contraception at a teenagers drop in clinic on Mondays from 4pm or by attending a morning appointment during the minor illness clinics.

Other weekly clinics related to minor illnesses, ante-natal care, baby and childhood vaccinations, travel immunisations, minor surgery and cryotherapy. The

practice also hosted consultant clinics in respect of general surgery (including colorectal), anti-coagulation, orthopaedics and dermatology. These services were designed to save patients' time and effort in travelling over to Sheffield or Chesterfield for outpatient appointments.

The practice was committed to promoting breast feeding and mothers accessed a weekly baby clinic and spent time socialising with other mothers. The practice staff felt this service was essential in such a rural setting to allow new mothers to gain confidence and forge long lasting relationships. Additionally, this was useful in helping prevent post natal depression and allowing the children to have early interaction with those of similar ages.

The practice held weekly multidisciplinary team meetings to discuss patients with complex needs. For example, (those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register). These meetings were attended by GPs, district nurses, social workers and health visitors.

Preventative care was also discussed to ensure patients were treated more effectively in their own home and or care home. Where appropriate, referrals were made to secondary care. For example, the practice had identified 150 patients whom they described as needing "supportive care". This care included: rehabilitation and equipment to improve independence, carer arrangements, and regular monitoring by a health professional for older people, people experiencing poor mental health, people with long term conditions and / or in vulnerable circumstances.

National data showed that the practice was below the CCG referral rates for secondary and other community care services for most conditions; and all conditions nationally. This included one of the lowest referral rates in the CCG to hospitals, emergency admissions and A&E attendances.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. For example changes to the appointment system were made following patient concerns about telephone access and availability of appointment.

Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning of its services. For example, the practice had systems in place to enable tourists and scouts to register as temporary residents when they visited the local area (The Bakewell area is a centre for tourism particularly in the summer months).

Additionally, the practice website stated: "with effect from 5th January 2015 we will be able to register patients from anywhere in the country; this may be subject to patients not having complex or difficult medical conditions where access to a local surgery nearer to home would be safer and more appropriate as we would not be able to offer home visits to patients who live elsewhere". This ensured temporary residents could access GP and nursing services when needed. The CCG told us the practice was very responsive to tourist needs.

The majority of the practice population were English speaking patients and the practice catered for other different languages through translation services. This included Mandarin Chinese and Polish. The practice maintained a register of patients who were living in vulnerable circumstances and those with a learning disability.

A system for flagging vulnerability in their individual record was used to ensure staff were aware of their needs. The practice was engaged in multi-disciplinary working with other health and social care professionals, and voluntary agencies to support the needs of the most vulnerable in the practice population.

The premises and services had been adapted to meet the needs of patient with disabilities. For example, the practice was situated on the ground and first floors of the building with most services for patients on the first floor. A lift was in place to enable people with limited mobility to access the meeting rooms. The practice had ramp access and handrails at the front door of the building. An induction loop system was also available for use by patients with hearing aids.

We saw that children had access to a playing area and tables and chairs for were available. We saw that the waiting area was large enough to accommodate patients

Are services responsive to people's needs?

(for example, to feedback?)

with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

Access to the service

We found comprehensive information was available to patients about appointments on the practice website. This included how to book: telephone consultations, urgent appointments, home visits and appointments in person, by phone and through the website.

The GPs held surgeries at various times during the day between 8.30am and 5.50pm to meet the preferred times of patients. The practice's extended opening hours (6.30pm to 8pm on a Monday and from 7am to 8am on a Wednesday) were particularly useful to patients with work and school commitments.

The opening hours for the practice and the dispensary were: 8am to 8pm on Mondays; 8am to 6.30 pm on Tuesdays Thursday and Friday; and 7am to 6.30pm on a Wednesday. The national patient survey results published in January 2015 showed 80% of the 124 respondents were satisfied with the surgery's opening hours.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. For example, Derbyshire Health United provided the out-of-hours service from 6.30pm to 8.00am during the weekdays, from 6:30 pm on Friday to 8:00 am Monday morning and public holidays. Patients could also ring the 111 and 999 services depending on their circumstances. Information on the out-of-hours service was provided to patients.

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

- 95% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to the local CCG average of 86% and the national average of 85%.
- 90% of respondents find it easy to get through to this surgery by phone compared to the CCG average of 75% and the national average of 74%.
- 86% of respondents usually wait 15 minutes or less after their appointment time to be seen compared to the local CCG average of 71% and the national average of 65%.
- 82% described their experience of making an appointment as good compared to the CCG and national averages of 75%.

Most patients we spoke with were satisfied with the appointment system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. There had been very little turnover of GPs during the last five years and the practice did not use any locum GPs or nurses. This enabled continuity of care and appointments with a GP of choice.

We however received a few comments in respect of long waiting times to access an appointment with some of the GP partners. On review of the appointment system, we found appointments were available on 13 and 18 May 2015; which meant a wait of between one and six days if a patient called on the day of our inspection.

Staff told us a triage appointment system was introduced in April 2014. When unrestricted appointments ran out for receptionists to book into, patients names were added to a telephone consulting list for the duty doctor to call back. The duty doctor prioritised urgent requests, and pre-booked patients with a GP or other health professional where needed.

The management told us the use of a triage system and having a duty doctor each day had increased the number of appointments available to patients; and some patients' health needs were resolved over the phone without booking a face to face consultation. As a result, the duty GP had on average 70-80 consultations a day and hospital admission rates remained relatively low.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice and the PPG openly discussed how patients were initially not happy with the change in appointment system. However, recent patient survey results showed a significant improvement in patient satisfaction in being able to obtain an appointment and / or speak with a GP. Positive patient feedback had been received based on their experience of the system and further information provided to explain how it worked.

We found reasonable adjustments had been made to ensure the appointment requirements for different population groups were met. For example, longer appointments and home visits were available for older people, those with long-term conditions and those who could not or would not leave their home. This included appointments with a named GP or nurse.

Appointments were available outside of school hours for children and young people. Forty minute appointments were offered when undertaking annual reviews for people with learning disabilities and patients experiencing poor mental health. GP and nurses added more consultations to their normal working day if patient demand was high. Flexible drop in services and appointments, including for example, avoiding booking appointments at busy times for people who may find this stressful were available.

Home visits were made to five local care homes on a specific day each week, by a named GP and / or community matron to those patients who needed one. The practice also provided daily GP cover to the local community hospital. We mostly received positive feedback from care home managers about the responsiveness of the GPs and community matron to the care needs of their residents.

Listening and learning from concerns and complaints

We found information was available to help patients understand the complaints system. This included posters displayed in the waiting area and information on the practice website. Some of the patients we spoke with were aware of the process to follow if they wished to make a complaint and others said they would tell the GP or manager.

The practice's complaints policy and procedure was in line with recognised guidance and contractual obligations for GPs in England. It included information on how to complain, the action the practice would take and other services that could be contacted if the patient was not happy with the outcome or needed advocacy support. This included the Health Services Ombudsman and Pohwer (an independent complaints advocacy service available in the Derbyshire area).

The practice manager was the designated person who handled all complaints in the practice We found suitable systems were in place to ensure patient complaints were listened to and acted upon to improve their quality of care.

Records reviewed showed 30 complaints had been received since 1 April 2014 and the level of reporting ensured a robust picture of patient concerns. We looked at 10 complaints received in the last 12 months. The complaints had been acknowledged, investigated within a timely way and responded to the patient's satisfaction where possible. An apology was also made to the patient where complaints were substantiated.

Staff we spoke with told us there was an open and transparent culture in reviewing complaints and making suggestions to improve the patient's experience. Records reviewed including the PPG meeting minutes showed evidence of shared learning with staff and the PPG members.

The practice leadership had produced a letter explaining why the practice had to change the appointment system in response to complaints about accessing appointments and verbal abuse to staff. This letter was displayed on the practice website.

The practice reviewed complaints to detect themes or trends. We looked at the report for the last review and themes identified included difficulty with telephone access and appointments (when the triage system was introduced) and staff attitude. We saw that lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision that had quality and safety as its top priority so as to promote good outcomes for patients. All the staff we spoke with demonstrated a shared ownership of the vision and knew what their responsibilities were in relation to this. Staff confirmed they had discussed and agreed that the vision and values were still current.

The values of the practice had a strong focus on patients, quality, compassion and staff. Staff we spoke with gave examples of how they promoted person centred care and a good quality service that was accessible to all patients. This was confirmed by most patients we spoke with, evidence we gathered from all stakeholders and nationally reported data on patient satisfaction. The practice charter and mission statement was clearly displayed in the waiting areas and staff areas.

Two outstanding areas of how the practice worked to achieve its vision and improve patient outcomes included: a collaborative approach to working with other multi-disciplinary professionals; and a continuous drive to improve service delivery through open and active engagement with staff, patients and external stakeholders. For example, the practice has been facilitating multi-disciplinary meetings for about 14 years and discussions centred on the needs and experience of patients.

We attended this meeting on the day of our inspection and observed a systematic approach was in place to review clinical outcomes for patients, patient safety, resources required to meet patients' needs and the effectiveness of partnership working. Discussions also included delivery of coordinated care for older patients with complex needs, palliative conditions and dementia.

Data reviewed confirmed positive outcomes were achieved for patients and there were benefits for the local health services. This included reduced unplanned hospital admissions and a broad range of services being delivered at the practice.

The leadership of the practice were of the view that shared care was one of their strengths and were open to improving their clinical leadership based on best guidance. Examples given included how the practice was continuously working to improve on prevention and integrated health and social care in line with the NHS five year forward view.

The NHS Five Year Forward View was published on 23 October 2014 and shows why change is needed in delivery of health services and what it will look like in the future. All of these new care models emphasise the need to deliver care designed around individual needs to deliver better outcomes for patients.

The leadership demonstrated an awareness of the challenges faced by the practice and actions needed to address them. For example, the leadership was in discussion with another local GP practice to merge as part of succession planning and staff were aware of this future plan.

This information was due to be discussed with its patient participation group (PPG) at the June 2015 meeting. The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Governance arrangements

There was clear evidence of robust and comprehensive oversight and governance of the practice. There was a commitment to assessing and monitoring the quality of the service, taking account of the views of patients, the CCG, local and national guidance and priorities and staff feedback and ideas.

Risk was identified proactively with action taken to assess this in a consistent and robust manner; as well as to mitigate against this as far as possible, bearing in mind patient views and preferences. There was a whole team approach to effective governance.

The practice had comprehensive policies and procedures in place to govern activity and support staff. These were available to staff on the desktop on any computer within the practice. We looked at 18 of these policies and procedures and found they had been reviewed and were up to date.

Are services well-led?

Outstanding ☆

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

Some staff had signed to confirm they had read the policies. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

We were shown a clear leadership structure with named members of staff in lead roles. For example, GPs had lead roles in patient safety, clinical governance, safeguarding, care home and partnership working. The GPs we spoke with demonstrated ownership of their clinical lead roles and performance data reflected improved outcomes for patients.

This included data from the Quality and Outcomes Framework (QOF) used to measure the practice's performance. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The 2013/14 QOF data showed the practice was performing above national and local averages in all clinical areas assessed. The practice had achieved an overall 99.7% QOF points which was 6.2% above the national average and 2.1% above the local Clinical Commissioning Group (CCG) average. The practice had also achieved the same score for 2014/15. We saw that QOF data was regularly discussed as a team and agreed actions plans were implemented and reviewed to improve outcomes.

The GP partners and management team took an active leadership role in assessing and monitoring the quality of service provision. For example, the practice had an on-going programme of clinical audits which it used to identify where action should be taken, in line with the National Institute for Health and Care Excellence (NICE) guidance and best practice. Audits reviewed related to the care for patients receiving warfarin treatment and controlled drugs.

The GP partners attended external meetings such as the CCG clinical governance meetings held every quarter and locality meetings with other GP practices within the area. The practice is a member of the North Dales CCG federation and the dales locality cluster. The practice regularly submitted governance and performance data to the CCG.

The GPs and community matron told us about a local peer review system they took part in with neighbouring GP practices. We looked at the reports from the last peer review, which showed the practice had the opportunity to measure its service against others and identify areas for improvement.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed. All of the staff we spoke with were clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and any areas that needed addressing and action plans had been produced and implemented. For example risk assessments were in place for visual display use (computer) and staff allergies. We saw that the risk log was discussed at some team meetings and updated in a timely way.

Leadership, openness and transparency

The leadership of the practice was strong and consistent and the culture of striving for continuous improvement was embedded in all systems and processes. The GP partners and management team had a visible presence in the practice.

Staff told us they were approachable and always took time to listen them. Examples given included: staff involvement in discussions about how to develop the practice, appropriate action being taken as a result of concerns raised and the practice manager having an open door policy to discuss any concerns or suggestions.

Staff consistently reported that they loved coming to work. Two staff members gave specific examples of what they described as pastoral care and one to one support following periods of ill-ness and bereavement within their families.

We found there were high satisfaction levels amongst staff and low turnover. Staff confirmed this was linked to the strong leadership and supportive culture within the practice. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so. They said they felt respected, valued and supported.

Are services well-led?

Outstanding ☆

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with told us they had no cause to use this policy.

Seeking and acting on feedback from patients, public and staff

The practice actively encouraged and valued feedback from patients. It had gathered feedback from patients through patient surveys, family and friends test, comment cards, compliments and complaints received. The practice had produced a bi-annual newsletter since Autumn 2010 which was distributed to various outlets around the town. Information contained included services available within the practice, physical activities within the area and recipes for example.

The practice had an active PPG which had been established since 2004. The PPG comprised of 14 regular members who met bi-monthly on a Tuesday evening; but were changing to quarterly meetings.

The PPG members mainly comprised of patients aged 50 and above; and the group was aware some population groups were underrepresented. The PPG encouraged teenagers and working age people to join by promoting the group at teenage health clinics, links with the local secondary school, the mother and baby group, and the new patient questionnaire.

We spoke with four PPG members and received written correspondence from one PPG member. They all told us there was genuine interest and a high level of engagement with the practice to ensure patient feedback was used to improve the services. For example, the practice had produced pocket sized information cards in response to survey results which showed 50% of patients were not aware of the opening hours.

The "did you know" card included the practice's telephone number, information on appointments and urgent care centres. The PPG members told us the cards were distributed within the village shops and also published in the parish magazines. They all agreed that the PPG played a "critical friend" role which drove improvement.

The PPG had taken a lead in encouraging patients to complete "Have your say on flu day" questionnaire. Four hundred and eighty one responses were received and most of the patients were happy with the service.

The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. One of the PPG members was also the chair for the local PPG network which aimed to share best practice drive improvement.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff felt involved and were committed to improving outcomes for patients. For example, the practice had reviewed and strengthened its processes for dealing with patient safety information in response to staff feedback.

Staff consistently described themselves as a mutually supportive team with a "can do attitude". Practice staff were given an extra day of annual leave on their birthday.

Management lead through learning and improvement

The GP partners held strategic roles with other agencies and were committed to wider working with other agencies to improve patient care within the practice and the locality. For example, the senior partner supported the CCG in undertaking quality visits which enabled local practices to benchmark themselves and make improvements to patient care.

The CCG confirmed no concerns were identified at the practice's most recent quality visit and clinical outcomes were consistently high and above CCG average. The senior partner was also the chair person for Derby and Derbyshire Local Medical Committee (LMC). The LMC represent and support GPs.

Another GP partner had a strong focus to driving improvement and sharing best practice for end of life care arrangements including provision of anticipatory medicines within the CCG area. The GP partner told us a significant amount of funding had been awarded for education related to end of life care within the CCG area and local hospitals.

The practice volunteered for CCG pilot schemes such as delivering of the community dermatology service. The GPs found this valuable in promoting a culture of continuous improvement and implementing evidence based practice in the delivery of patient care.

Are services well-led?

Outstanding ☆

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff described the management as having a supportive approach to staff development and this included protected learning time at least once a month.

The practice was a GP training practice and two of the GP partners were educational supervisors. At the time of our inspection there was one GP registrar present and they provided very positive feedback in respect of their learning experience within the practice. There was an administrative apprentice who confirmed receiving adequate support and induction.

We saw that performance data, incidents and complaints were effectively used to identify areas where improvements could be made. Processes were in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. There was an open culture in which all safety concerns were highly valued as integral to learning and improvement. The community matron met with care home managers at least every quarter to specifically review the GP service as part of a quality assurance process.