

Arden House Medical Practice

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Arden House Medical Practice on 22 August 2016. Overall, the practice is rated as good.

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

- Patients overwhelmingly told us they received excellent care and were treated with compassion, dignity and respect. They also said they were involved in their care and decisions about their treatment. This was corroborated by the outcomes of the latest national GP patient survey, friends and family test results, and CQC comment cards.
- There was an effective system in place for the reporting and recording of significant events. Learning was applied from events to enhance the delivery of safe care to patients.
- Clinicians kept themselves updated on new and revised guidance and discussed this at clinical meetings. Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- We saw evidence of an active programme of clinical audit that reviewed care and ensured actions were implemented to enhance outcomes for patients.
- The practice planned and co-ordinated patient care with the wider health and social care multi-disciplinary team to deliver effective and responsive care and keep vulnerable patients safe. Weekly meetings took place to discuss and review patients' needs.
- The practice directly employed a part-time community matron and part-time care co-ordinator to facilitate the delivery of care to support patients in their own homes.
- The practice employed care co-ordinator held monthly meetings with the social worker to help integrate health and social care planning and provision to patients.

Summary of findings

- The practice had an appraisal system in place and supported staff training and development. The practice team had the skills, knowledge and experience to deliver high quality care and treatment.
- Arrangements in place to assess and manage risk were not always sufficiently robust. For example, the practice did not have a defibrillator and had no risk assessment or written protocol to cover its absence. Whilst unused water outlets were regularly run, the practice had not undertaken a legionella risk assessment.
- Feedback from patients demonstrated that patients felt they had excellent access to GP appointments. This was supported by the results of national GP patient survey.
- Longer appointments were available for those patients with more complex needs, and there was greater flexibility in offering appointments for vulnerable patients such as those with a learning disability.
- The practice had good facilities and was well-equipped to treat patients and meet their needs. The premises were accessible for patients with impaired mobility.
- There was a clear leadership structure in place and the practice had a governance framework which supported the delivery of good quality care. Regular practice meetings occurred, and staff said that GPs and managers were approachable and always had time to talk with them.
- The partnership had a clear vision for the future of the service, and were engaged with their Clinical Commissioning Group (CCG) in order to progress this.

- The practice had an open and transparent approach when dealing with complaints. Information about how to complain was available, and improvements were made to the quality of care as a result of any complaints received.
- The practice did not have an active patient participation group (PPG) at the time of our inspection, but they were reviewing the potential to develop a virtual group. The practice was keen to receive patient feedback from a variety of sources, which they acted upon.

The areas where the provider must make improvements is:

- Ensure they are doing all that is reasonably practicable to mitigate risks; specifically the provider must ensure they take appropriate action to mitigate the risks identified in their recent defibrillator risk assessment taking account of national guidance.

The areas where the provider should make improvement are:

- Formalise their assessment of risk in relation to legionella.
- Review induction documentation for new starters and include evidence that all of the content has been covered and signed-off as completed.
- Review the training of staff who act as chaperones to ensure they are clear on their responsibilities.
- Ensure a documented action plan is in place following infection control audits, and that this is updated as actions are completed

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?

- Staff were supported to report significant events in a supportive environment. Learning was applied from incidents to improve safety in the practice.
- The practice had robust systems in place to ensure they safeguarded vulnerable children and adults from abuse.
- The practice worked to written recruitment procedures to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- There were systems in place to manage medicines on site appropriately.
- Patients on high-risk medicines were monitored on a regular basis, and there were processes in place to follow up any patients who had not collected their prescriptions. Actions were taken to review any medicines alerts received by the practice, to ensure patients were kept safe.
- The practice had systems in place to deal with medical emergencies, although they did not have their own defibrillator. There was access to a community defibrillator. The practice undertook a risk assessment to review the risk of not having this equipment but had not taken action to mitigate this risk.
- Risks to patients and the public were generally well managed although the practice had not undertaken a risk assessment for the control of legionella.
- The practice had developed contingency planning arrangements supported by an up to date written plan that was regularly updated.

Requires improvement



Are services effective?

- The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The practice had acquired a total achievement of 97.3% for the Quality and Outcomes Framework (QOF) 2014-15. This was marginally below the CCG average of 98.1%, and above the national average of 94.7%.
- The practice worked collaboratively with the wider health and social community to plan and co-ordinate care to meet their

Good



Summary of findings

patients' needs at a weekly multi-disciplinary team meeting. An additional monthly meeting held by the practice's care co-ordinator with the social worker helped to integrate health and social care planning arrangements.

- Staff had the skills and experience to deliver effective care and treatment. New employees received inductions, and all members of the practice team had received an appraisal in the last year, which included a review of their training needs.
- The practice received regular input from a community pharmacist and a CCG medicines management technician to provide support on medicines and prescribing matters.
- We saw examples of how clinical audit was being used to improve quality and enhance safe patient care and treatment.

Are services caring?

- We observed a patient-centred culture and approach within the practice. Staff treated patients respectfully and with kindness.
- Data from the latest GP survey in July 2016 showed that patients rated the practice higher than local and national averages in respect of the care they received.
- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated that they felt treated with compassion and dignity, and were given sufficient time during consultations. Patients said they were involved in decisions about their care and treatment.
- Feedback received from care home staff and a member of the community nursing team was positive about the high standards of care provided by the practice team.
- The practice had identified 2% of their list as being carers, which was in line with expected averages. Information was available on the various types of support available to carers. The practice was not providing any specific services or support for carers apart from their inclusion in the annual flu vaccination programme.
- We were informed of examples in which the practice had provided high levels of care to individual patients. This included the ongoing support and care for a patient with a learning disability, and the support given to a patient who was now able to self-manage their condition following extensive input initially from the practice team.
- As a small semi-rural practice, the team knew their patients very well. This aided them in providing personalised care and ensured greater continuity for patients.

Good



Summary of findings

Are services responsive to people's needs?

Good



- Comment cards and patients we spoke with during the inspection provided consistently positive experiences about obtaining an appointment with a GP. The latest GP survey showed that patient satisfaction was significantly above local and national averages with regards access to GP appointments.
- There was in-built flexibility within the appointment system including pre-bookable slots; telephone consultations; and 'on the day' urgent appointments.
- Patients could book appointments and order repeat prescriptions on line. The practice participated in the electronic prescribing scheme, so that patients could collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- The practice hosted some services on site including a hearing assessment clinic and a weekly Citizens Advice Bureau session. This made it easier for their patients to access services locally.
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The premises were tidy and clean and well-equipped to treat patients and meet their needs. The practice accommodated the needs of patients with disabilities, including access to the building through automatic doors.
- The practice reviewed any complaints they received and dealt with these in a sensitive and timely manner. Information about how to make a complaint was available for patients. Learning from complaints was used to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they could be offered a more private area to ensure their privacy.

Are services well-led?

Good



- The partners were committed to delivering high quality care and promoting good outcomes for their patients.
- There was a clear staffing structure in place. GPs and nurses had lead roles providing a source of support and expert advice for their colleagues.
- The practice had developed a range of policies and procedures to govern activity.
- The partners worked collaboratively with other GP practices in their locality, and with their CCG. They were proactively engaged with the CCG's strategy to deliver care closer to people's homes.

Summary of findings

- The partners reviewed comparative data provided by their CCG and ensured actions were implemented to address any areas of outlying performance.
- Staff felt well supported by management, and the practice held regular staff meetings.
- The practice had sought feedback from patients, and acted on this to improve service delivery. The practice did not have an active patient participation group (PPG) at the time of our inspection.

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

Good



- The practice directly employed their own community matron and care co-ordinator. This facilitated care for patients being discharged from hospital, or provided support to help patients remain in their own home.
- The needs of older people with more complex needs were reviewed at a weekly multi-disciplinary team meeting. The care co-ordinator met monthly with the social worker to review individual patients in greater depth. This helped to integrate the health and social needs for patients to produce a more comprehensive and personalised package of care.
- Longer appointment times could be arranged for those patients with complex care needs, and home visits were available for those unable to attend the surgery.
- The practice pharmacist and matron undertook medicines reviews for those patients that were housebound. The pharmacist also reviewed the use of multiple prescribed medicines.
- Uptake of the flu vaccination for patients aged over 65 was 70.8%, which was in line with local (73.9%) and national (70.5%) averages.

People with long term conditions

Good



- The practice undertook annual reviews for patients on their long-term conditions registers, including a review of their prescribed medicines. These were undertaken more frequently for individual patients that had more complex needs.
- QOF achievements for clinical indicators were in line with CCG and averages, and slightly above national averages. For example, the practice achieved 97.7% for diabetes related indicators, in comparison to local and national averages of 96.7% and 89.2% respectively.
- The recall system was co-ordinated by the administration team who undertook monthly searches and followed-up any patients that were overdue.
- Patients with multiple conditions were usually reviewed in one appointment to avoid them having to make several visits to the practice. The appointment was extended by up to 45 minutes to accommodate this.
- There was a lead designated GP or nurse for all the clinical domains within QOF.

Summary of findings

- A specialist diabetes nurse attended the practice occasionally to undertake a joint clinic with the practice nurse to manage complex patients with diabetes. Patients had been allocated up to one hour's appointment time to facilitate this review. In addition, the practice undertook foot checks for low-risk patients with diabetes, and also held a fortnightly eye clinic to assess the sight of patients who had diabetes.
- All patients with a long-term condition were offered an annual flu vaccination. Patients were contacted individually to arrange an appointment to ensure the highest possible uptake.

Families, children and young people

Good



- Same day rapid access was provided for unwell babies or children. Routine appointments for children were available outside of school hours.
- The GPs saw new mothers for a post-natal review and a six-week baby check.
- Childhood immunisation rates were in line with local averages. Rates for the vaccinations given to children up to five years of age ranged from 69.4% to 100% (local averages 95.2% to 99.1%). Non-attendance was followed up and cases would be referred to the health visitor if that had been repeated non-engagement.
- The practice had an identified lead GP for child safeguarding. The health visitor and school nurse attended the practice multi-disciplinary team meetings on a monthly basis to review and discuss any child safeguarding concerns. Child protection alerts were used on the clinical system to ensure clinicians were able to actively monitor any concerns.
- Family planning services were provided including the provision of long-acting reversible contraceptives and advice and support on all aspects of contraception. Patients could access a family planning clinic in New Mills to fit and remove intrauterine devices (coils). Chlamydia screening kits were available in corridors.
- The practice worked within their local community to promote health – for example, children from a local nursery had visited the practice to increase their understanding about going to see a doctor. A GP had given a talk to schoolchildren about the doctor's surgery.
- The practice had baby changing facilities, and welcomed mothers who wished to breastfeed on site. A private room could be offered for breastfeeding mothers if this was requested, and information was available on local breastfeeding groups.

Summary of findings

Working age people (including those recently retired and students)

Good



- The practice offered on-line booking for appointments and requests for repeat prescriptions. The practice provided electronic prescribing so that patients on repeat medicines could collect them directly from their preferred pharmacy.
- Telephone consultations were available meaning that patients did not have to travel to the practice unnecessarily.
- The practice promoted health screening programmes to keep patients safe. NHS health checks were available.
- The practice did not offer any extended hours consultations at the time of our inspection. However, feedback from patients was overwhelming positive about obtaining a GP appointment.

People whose circumstances may make them vulnerable

Good



- The practice had undertaken an annual health review in the last 12 months for 79.3% of patients with a learning disability. The remaining patients declined the assessment.
- The practice had a higher prevalence of registered patients with a learning disability as they covered two residential homes for this patient group. The practice had a dedicated nurse to lead on patients with a learning disability who visited each home weekly and reviewed all patients on a quarterly basis. All these patients had a care plan in place.
- The lead nurse for learning disabilities liaised with the learning disabilities specialist nurse whenever any challenging issues required an expert view.
- A GP partner was accredited as a GP with a Special Interest (GPwSI) in substance misuse and worked with the local substance misuse service to provide support for patients. This service was available to all local residents, and not just for registered patients.
- Patients with end-of-life care needs were reviewed at weekly multi-disciplinary team meetings. The practice worked closely with the district nursing team to deliver responsive care to these patients.
- The practice referred or signposted patients to the 'Wrap-around Care Project' funded by their CCG. This provided a point of first contact for health professionals to access the voluntary sector within the locality. Service available included befriending, transport and shopping with the aim of keeping people independent in their own homes, or to regain confidence following a hospital discharge.

Summary of findings

- Staff had received adult safeguarding training and were aware how to report any concerns relating to vulnerable patients. There was a designated lead GP for adult safeguarding.
- The practice was a recognised safe haven for people with a learning disability. This Derbyshire partnership scheme aimed to protect people with learning disabilities from potential bullying or abuse, and helped them feel safe and confident within the community by having access to a place where they could be supported if required.
- Longer appointments and home visits were available for vulnerable patients.

People experiencing poor mental health (including people with dementia)

Good



- The practice achieved 100% for mental health related indicators in QOF, which was 1.9% above the CCG and 7.2% above the national averages. Exception reporting rates for mental health related indicators were generally slightly higher than local and national rates.
- 93.3% of patients with severe and enduring mental health problems had a comprehensive care plan documented in the preceding 12 months according to 2014-15 QOF data. This was in alignment with the CCG average and 5% above the national average of 88.5%.
- Although there was no access to counselling or associated talking therapies' services on site, patients could access services in nearby Buxton or Whaley Bridge.
- The practice worked with local community mental health teams and had established a good relationship with the community psychiatric nurse (CPN), who regularly attended the multi-disciplinary team meetings.
- The practice reviewed patients who had attended hospital for issues relating to self-harm.
- The practice carefully monitored patients who were taking high-risk medicines for their mental health condition.
- 88.5% of people diagnosed with dementia had had their care reviewed in a face-to-face meeting in the last 12 months. This was higher than local and national averages by approximately 4.5%. Exception reporting rates were also lower at 3.7%, compared to the local and national average of 8.3%.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016, and the results showed the practice was generally performing in line with local and national averages. There were 237 survey forms distributed to patients, and 118 of these were returned. This was a 50% completion rate of those invited to participate, and equated to 3.2% of the registered practice population.

- 97% of patients found the receptionists at this surgery helpful compared against a CCG average of 89% and a national average of 87%.
- 74% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 71% and a national average of 65%.
- 91% of patients said they would recommend this surgery to someone new to the area compared to a CCG average of 84% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 33 comment cards which were all extremely

positive in respect of the level of care provided and the interactions with the whole practice team. Patients said they were treated in a caring and respectful manner by staff. They also said they were given sufficient time and were listened to during their consultations. There were two minor negative comments in relation to obtaining an appointment to see a GP.

All of the 12 patients we spoke with during the inspection said that they were treated as an individual with politeness and respect by the practice staff. Patients reported a high level of satisfaction regarding their consultations, stating that they were provided with sufficient consultation time and that they felt informed and involved in their care. Patients told us they were satisfied with the appointment system and specifically the availability for same day consultations. One patient told us it would be useful to receive an indication of how long they needed to wait if appointments were running late.

Areas for improvement

Action the service **MUST** take to improve

- Ensure they are doing all that is reasonably practicable to mitigate risks; specifically the provider must ensure they take appropriate action to mitigate the risks identified in their recent defibrillator risk assessment taking account of national guidance.

Action the service **SHOULD** take to improve

- Formalise their assessment of risk in relation to legionella.

- Review induction documentation for new starters and include evidence that all of the content has been covered and signed-off as completed.
- Review the training of staff who act as chaperones to ensure they are clear on their responsibilities.
- Ensure a documented action plan is in place following infection control audits, and that this is updated as actions are completed

Arden House Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Arden House Medical Practice

Arden House Medical Practice provides care to approximately 3,650 patients in New Mills, a town situated approximately eight miles south-east of Stockport in the High Peak area of North Derbyshire. The practice provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The site operates from a purpose built two-storey building constructed six years ago. All patient services are provided on the ground floor and the upper floor is currently unoccupied.

The practice is run by a partnership of two GPs (one male and one female) who employ one part-time female salaried GP.

The nursing team consists of a part-time community matron, a part-time practice nurse, and one part-time health care assistant. The clinical team is supported by a practice manager, a care co-ordinator, and a team of six administrative and reception staff.

Medical students are due to undertake placements within the practice from September 2016.

The registered patient population are predominantly of white British background with an age profile which is generally consistent with local averages. The practice is ranked in the third least deprived decile and whilst situated in an area of relatively high affluence, it also serves pockets of higher deprivation.

The practice operates across two sites within a semi-rural location. We visited the main site at Sett Close for our inspection. There is also a branch site at 15/17 New Mills Road, Hayfield, Stockport, Cheshire, SK22 2JG.

The practice's main site opens daily from 8am until 6.30pm. The practice closes on one Wednesday afternoon each month for staff training.

Scheduled GP morning appointments times at the main site vary each day according to the GP on duty. Start times vary from 8.30am-9.30am and run until 11am or 11.30am. Afternoon GP surgeries times vary each day with the first appointment commencing between 2.50-4pm, and run until 5-6pm. GP appointments at the branch surgery are offered on Tuesday, Thursday and Friday mornings, and on Thursday afternoons.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed, patients with urgent needs are directed via the 111 service to a locally based out-of-hours and walk-in urgent care centre in New Mills operated by Derbyshire Health United (DHU). This opens from 6.30pm to 10.30pm each weekday, and from 9.30am until 10.30pm at weekends and bank holidays. Patients also have access to a minor injuries unit in Buxton. The nearest Accident and Emergency (A&E) units are based in Macclesfield and Stockport.

Detailed findings

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

We carried out an announced inspection on 22 August 2016 and during our inspection:

- We spoke with staff including GPs, the practice nurse, the community matron, and reception and administrative staff. In addition, we spoke with representatives from two local care homes, the social

worker attached to the surgery, and the district nursing team, regarding their experience of working with the practice team. We also spoke with 12 patients who used the service.

- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 33 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record and learning

There was a procedure in place for reporting and recording significant events

- A significant event reporting form was available to all staff electronically. Twelve significant events had been reported over the course of the last 18 months.
- The practice encouraged staff to report incidents within a supportive 'no blame' culture.
- Completed forms were sent to the practice manager to assess whether any urgent or remedial action was indicated to protect patients or staff.
- The practice discussed incidents at monthly staff meetings where significant events were a standing agenda item. We saw that notes were recorded from the meetings and these provided evidenced that learning had been applied. The significant event template forms were not always completed to record that agreed actions had been completed, although we were assured these were always followed up through the staff meetings.
- We saw examples of learning that had been applied following a significant event. For example, we saw that the practice had liaised with the hospital following confusion over communication. This resulted in a cover sheet being developed which detailed any additional action to be taken by the practice.
- People received support and an apology when there had been unintended or unexpected safety incidents. The practice recognised their duty of candour and informed us they would either meet with the person or write to them, depending on the particular circumstances involved.

The practice had a process to review alerts received including those from the Medicines Health and Regulatory Authority (MHRA). When concerns were raised about specific medicines, patient searches were undertaken to identify which patients may be affected. Effective action was then taken by clinicians to ensure patients were safe, for example, by reviewing their prescribed medicines.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local guidance and policies were accessible to staff. Practice safeguarding policies were accessible and up-to-date, and alerts were used on the patient record to identify vulnerable children and adults. There were designated lead GPs for safeguarding both children and adults, who had received training at the appropriate level in support of the role. The health visitor, and on occasions the school nurse, attended a monthly multi-disciplinary team meeting to discuss any child safeguarding concerns. Minutes of the meeting were available for other clinicians to view. Practice staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- Vulnerable adults were monitored by the practice team and staff were aware how to report any safeguarding concerns regarding adults. The practice team had received update training on adult safeguarding, and had received an overview of female genital mutilation (FGM) to raise awareness of this issue, during protected learning time sessions in 2016.
- A notice in the reception and the consulting rooms advised patients that a chaperone was available for examinations upon request. Members of the reception team had undertaken training in support of this role and would act as a chaperone if a nurse or health care assistant were not available. However, we spoke with some staff who were not fully aware of their responsibilities as chaperones. Staff who undertook chaperoning duties had received a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). A practice chaperone policy was available.
- We observed that the practice was tidy and maintained to good standards of cleanliness and hygiene. The practice nurse was the appointed infection control lead, who had undertaken training in support of the role. There were infection control policies in place, including handwashing techniques and the handling of samples, and we observed these had been reviewed regularly. Practice staff had received infection control training and received information as part of new staff inductions. An infection control audit had been completed in March 2016. We did not see documented evidence of an action plan to address the identified issues although we were

Are services safe?

assured that the practice had completed actions in response to the findings. The practice used contractors to provide their cleaning services and written schedules of cleaning tasks were available. The practice manager met with the cleaning contract manager every six months and would discuss any issues relating to the service being provided. Documentation was available to support the control of substances hazardous to health including any spillages.

- We reviewed three staff files and found that the necessary recruitment checks had been undertaken prior to commencing work with the practice. For example, proof of identification, qualifications, registration with the relevant professional body and the appropriate checks through the DBS.
- The practice had a robust system to manage incoming correspondence to ensure that any actions, such as a change to a patient's medicines, were completed promptly. GPs ensured that they reviewed the pathology results for their colleagues if they were absent.

Medicines management

- The arrangements for managing medicines in the practice, including emergency medicines and vaccinations were generally safe.
- Blank prescription forms and pads were securely stored although repeat prescription requests were placed in an unsecured box on the reception desk. Regular medicines stock checks including expiry dates were undertaken. Signed and up-to-date Patient Group Directions were in place to allow nurses to administer medicines in line with legislation, and healthcare assistants administered medicines against a patient specific prescription or direction from a prescriber.
- Systems were in place to monitor patients prescribed high-risk medicines, and warning signs were displayed on the computer prescribing recall system. Monitoring included a nurse-led INR clinic for patients prescribed medicines to control anti-coagulation (the clotting of blood).
- There was a process and written policy in place in support of repeat prescriptions. Uncollected prescriptions were destroyed after six months. There were mostly informal procedures in place to monitor this, and we were told that the reception team would contact some patients to remind them, or determine if there may be a problem.

Monitoring risks to patients and staff

- A practice health and safety policy was available and the practice fulfilled their legal duty to display the Health and Safety Executive's approved law poster in a prominent position.
- Some basis generic risk assessments were available but the process was not being used to proactively manage any new or emerging risk areas. For example, there was no risk assessment in place to cover the absence of a defibrillator on site.
- A comprehensive external fire risk assessment had been undertaken by a fire safety specialist in 2013. This had resulted in an action plan and we saw evidence that the practice had responded to all the issues that had been identified. There had been no further updates as there had been no changes to the site, however, the practice were aware that this would need to be reviewed if, for example, the upper floor was commissioned. Fire alarms and extinguishers were serviced regularly to ensure they were in full working order. The alarm was tested weekly and emergency lighting was checked on a monthly basis, and this was recorded. Staff had received regular fire training, and the practice undertook trial evacuations to ensure staff were aware of the procedure to follow in the event of a fire.
- All electrical equipment was regularly inspected to ensure it was safe to use, and medical equipment was calibrated and checked to ensure it was working effectively. We saw certification that this had been completed by external contractors in the last 12 months.
- The practice had not completed a risk assessment for legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings). We were informed that this had been arranged following our inspection and was planned to take place in October 2016. Monthly testing of water sources was undertaken and recorded by an external provider for site maintenance.
- There were arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. GPs arranged cover between themselves, the practice did not use locum GPs. A former receptionist who had retired helped to cover periods of staff leave when required.

Arrangements to deal with emergencies and major incidents

Are services safe?

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

- Staff had received annual basic life support training. We saw evidence that the team had received this training in July 2016.
- The practice did not have an automated external defibrillator (AED) for treating patients who had heart attacks. An AED is a portable electronic device that analyses life-threatening irregularities of the heart and is able to attempt to restore normal heart rhythm. According to current advice, GP practices should be encouraged to have a defibrillator. The practice told us that based on the number of patients registered at the practice and the number of occasions when patients required emergency treatment, it had been concluded that an AED was not essential equipment. However, we were informed that the practice would use a defibrillator that was available at a nearby public house, although there was no written procedure or evidence of staff being informed how to access this. Following the inspection the practice undertook a formal risk assessment which determined that an AED should be

purchased. However, the practice planned to raise funds to cover the cost of this and estimated this could take a year. Therefore, we were not assured that the practice was doing all that was reasonably practicable to mitigate this risk. The practice did have a resuscitation bag for emergency use with a portable oxygen cylinder and different sized airways.

- A first aid kit and an accident book were available.
- Call systems on telephones and all computers alerted staff to assist rapidly with any emergency situation, such as if a patient were to collapse.
- The practice had a business continuity plan for major incidents such as power failure or building damage. This was reviewed regularly and updated as required. Copies of the plan were kept off site in case any incidents made entry to the site inaccessible. A laminated card containing key contact details had been produced to facilitate access to this information. As the practice had a branch site, there were arrangements to ensure continuity of service and access to records if one site was temporarily out of action.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, and local guidance, for example, in relation to prescribing. New guidance was discussed at clinical staff meetings. We saw that guidelines were used within templates on the practice computer with hyperlinks to the relevant information. For example, the template used for novel oral anticoagulants contained links to the Derbyshire prescribing guidelines.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2014-15) were 97.3% of the total number of points available. Exception reporting rates at 9.6% were marginally below the local average of 11% and in alignment with the national average of 9.2%. Exception reporting is the removal of patients from QOF calculations where, for example, a patient repeatedly fails to attend for a review appointment..

QOF data from 2014-15 showed:

- Performance for diabetes related indicators was 97.7%, which was in line with the CCG average of 96.7% and above the national average of 89.2%.
- The practice achieved 100% for clinical indicators related to chronic obstructive airways disease. This compared to a local average of 99.2% and a national average of 96%.
- QOF achievement for 2014-15 for asthma was 100% which was slightly higher than local and national averages (97.6% and 97.4% respectively).
- The only area of significant difference was in the achievement of 71.9% for indicators related to chronic kidney disease, which was 24.6% below the CCG average and 22.8% below the national average. The practice

explained this had been due to a coding issue which had now been corrected. Practice data for 2015-16 (as yet unverified) demonstrated that the achievement had increased to 84%.

There was evidence of quality improvement including a programme of clinical audit. The practice had devised an audit template to ensure consistency in how audits were undertaken.

- We saw evidence of a programme of audit, including four clinical audits undertaken in the last year. Two were completed full-cycle audits where changes had been implemented and monitored with positive outcomes for patients. We reviewed a full cycle audit on patients prescribed a particular medicine for gout, which was completed in 2015. Following the initial audit, guidelines relating to gout diagnosis and management were highlighted to the GPs. The second cycle audit repeated after ten months showed an increase in compliance with all the standards reviewed and this was accompanied by better documentation and improved practice in dealing with newly diagnosed patients with a diagnosis of gout.
- We saw that an audit had been initiated further to a significant event. This had arisen when a patient experienced a 'near-miss' incident by almost taking two different types of prescribed anticoagulation medicines at the same time. This could have created the patient being at potentially high risk of bleeding. The practice used this incident to consider the consistency of care and monitoring delivered to patients taking a particular anticoagulation medicine.
- The practice worked with a CCG medicines management pharmacy technician who visited regularly and carried out medicines audits to ensure prescribing was cost effective, and adhered to local guidance.
- The practice participated in local benchmarking activities. For example, they participated in annual quality focussed visits with the CCG to review comparative data including referral rates and hospital admissions. The CCG had queried the practice's rates of referrals to urology which had been high and then reduced by half. The practice had discovered this was mainly due to one patient and took action to address the patient's needs and formulated a care plan. The actions saw the referral rate reduce by half.

Effective staffing

Are services effective?

(for example, treatment is effective)

- The practice employed their own community matron and care co-ordinator. They contacted all patients being discharged from hospital within 48 hours to ensure their needs were met. The community matron role had helped to keep patients safe in their own homes. We were told how this had impacted upon the care of individual patients, for example, identifying when patients were hoarding prescribed medicines; and advising families on the support available to them to support a relative with dementia. The care co-ordinator met regularly with the social worker to ensure joined up health and social care for patients.
- The community matron was the dedicated nurse for patients with a learning disability, and also managed the practice's INR service. Whilst the three roles overlapped to some degree, each had defined hours to ensure that there was time allocated to sufficiently undertake core duties. Several practice staff had dual roles which created more flexibility and capacity within a small team.
- The practice provided an induction programme for all newly appointed staff. The documented evidence provided was limited in scope and therefore did not fully demonstrate that it incorporated all the relevant issues for new starters. Nor did it provide evidence that the topics within the induction had been signed-off as completed. However, staff told us they were well supported when they commenced their roles with shadowing opportunities and had easy access to support from their colleagues.
- Staff told us that they received an annual appraisal and we saw documentation that evidenced this. We spoke to members of the team who informed us of how learning opportunities had been discussed during the appraisal and supported by the practice. For example, the practice nurse had been supported with time to develop their skills in diabetes by developing joint working opportunities with the diabetes nurse specialist.
- The practice ensured role-specific training with updates was undertaken for relevant staff e.g. administering vaccinations and taking samples for the cervical screening programme.
- Staff received mandatory training that included safeguarding, fire safety awareness, and basic life support. Staff had access to and made use of e-learning training modules and in-house training. The practice

had protected learning time on one afternoon each month, when in-house training was organised for the practice team. GPs attended training events organised by their CCG on some of these months.

- The practice had supported nurses to attend events in support of their revalidation, and one nurse had already been successfully revalidated at the time of our inspection.
- A community pharmacist provided one session per week at the practice. This post was resourced via a reallocation of a proportion of the CCG prescribing budget for the practice. The pharmacist focused upon polypharmacy (the use of four or more medicines) issues in the over 75s and visited housebound patients to ensure there were no medicines compliance issues, for example, the stock-piling of medicines. The pharmacist also reviewed patients who were discharged from hospital to ensure their prescribed medicines were updated and correct.

Coordinating patient care and information sharing.

- The information needed to plan and deliver care and treatment was available to clinicians in a timely and accessible way through the practice's electronic patient record system. This included care plans, medical records, and investigation and test results. We viewed examples of care plans and saw that these were comprehensive and appropriate.
- Weekly multi-disciplinary meetings were held at the practice to assess the range and complexity of patients' needs, and to plan ongoing care and treatment for vulnerable patients including those at high risk of hospital admission. The meeting also provided the opportunity to discuss any child safeguarding concerns, and to review the care of any patients receiving palliative care. Practice representatives at this meeting included the community matron, care co-ordinator, practice nurse and GPs. Attendees from outside the practice included a social worker, district nursing team staff, a community psychiatric nurse, the health visitor and school nurse. These professionals attended the meeting when they had relevant patient to discuss with the practice. Brief minutes were produced from the meeting that made accessible to all practice clinicians, and patients' records were updated by the care co-ordinator following the meeting. The weekly meetings alternated between a Monday and Wednesday to accommodate the attendance of part-time staff and

Are services effective?

(for example, treatment is effective)

thereby facilitate a more inclusive approach. We observed one of these meetings during our inspection and saw that this worked effectively to address the needs of patients, for example, the early prescribing of medicines for patients approaching their end of life.

- In addition to the weekly multi-disciplinary meeting, the practice's care co-ordinator had a monthly with the social worker. This provided designated time to review patients in depth to ensure that their individual needs were being addressed adequately. This meeting was acknowledged as being extremely beneficial by both parties and the social worker was trying to encourage other practices to adopt a similar approach.

Consent to care and treatment

- Staff sought patients' consent to care and treatment in line with legislation and guidance.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. A GP had attended MCA and Deprivation of Liberty Safeguards (DoLS) training at a local hospital and cascaded this training to the practice team in November 2015.
- When providing care and treatment for children and young people, staff followed national guidelines to assist clinicians in deciding whether or not to give sexual health advice to young people without parental consent.

Supporting patients to live healthier lives

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

- The practice hosted a weekly session on site provided by the 'Live Life Better Derbyshire' service. This offered assessments for patients over 16 years of age to provide advice and signposting to relevant support schemes, for example, to stop smoking and to assist in weight management and promote more active lifestyles. This service would also visit housebound patients at home, or accompany people to attend appointments if they required some initial support.
- The practice was not providing new patient health checks, and NHS health checks for patients aged 40-74 at the time of our inspection. This service had been temporarily halted further to the departure of one of the health care assistants in March 2016. The practice aimed to resume this service with the appointment of a new health care assistant in September 2016.
- Data from QOF showed that that uptake rate for the cervical screening programme in the last five years was 80.7%, which was marginally below the CCG average of 84% and in line with the national average of 81.8%. National screening programme data showed the uptake for breast and bowel cancer screening was slightly below local averages, but was not significantly different to national averages.
- Childhood immunisation rates for the vaccinations given to children aged up to five years of age were generally in line with averages. The overall childhood immunisation rates for the vaccinations given to under two year olds ranged from 78.4% to 100% (local average 95.2% to 98.9%) and five year olds from 69.4% to 97.2% (local average 96.5% to 99.1%). Due to low numbers of eligible children, small numbers of non-immunisation accounted for the lower range outcomes achieved.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

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

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

- 98% of patients said the last GP they saw was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 97% of patients said the last GP they saw gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 96% of patients said the last GP they spoke to was good at treating them with care and concern compared to a CCG average of 90%, and the national average of 85%.

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

We were provided with an example of how the practice provided ongoing care and support to a vulnerable patient with a long-term condition and a learning disability. This individual called into the practice every day to talk to the staff, and clinicians would see the patient even when an appointment had not been made. If the patient did not

come to the practice for a few days, the practice would contact the local police community support officer to undertake a welfare check. The practice discussed this patient at regular multi-disciplinary team meetings and this had resulted in a vulnerable adults risk management (VARM) process being put in place. VARM is a multi-agency risk management process to enable professionals to come together to develop creative and assertive plans to support adults at risk who have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or by refusing previous offers of support from services.

Care planning and involvement in decisions about care and treatment

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

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

- 95% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 86%.
- 97% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87%, and the national average of 82%.

Patient and carer support to cope emotionally with care and treatment

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

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

The practice had identified 2% of the practice list as carers, and identified new carers upon registration. The practice had not formally identified a designated 'Carers' Champion', although the care co-ordinator partially performed role this via regular contact with the families of

Are services caring?

vulnerable patients. The practice encouraged carers to receive vaccination against the flu virus, but were not doing any proactive work to address their needs collectively. The care co-ordinator advised some carers regarding how they could obtain assistance, for example, with regard to respite care. Signposting details for carers were available in the reception area, and the practice website provided links to a range of helpful information for carers.

The practice worked with the wider multi-disciplinary team to deliver high quality end of life care for patients. A member of the district nursing team informed us that the practice always responded quickly to any requests for

support in the ongoing care of palliative patients. The patient's preferred place of death was recorded within the summary care record to facilitate this. Patient deaths were reviewed at team meetings to consider any learning to enhance future care delivery. The practice would send a letter of condolence following a patient's death and GPs would usually contact relatives directly if they had been closely involved in the individual's care. Information was provided to signpost relatives or carers to appropriate services such as counselling where indicated. There was poster about bereavement support in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG), to secure improvements to services where these were identified. For example, the practice wished to improve their premises in order to enhance the environment and to be able to provide more services to their patients. They had submitted a bid to the CCG in support of this proposal.
- One of the GP partners was a GP with a Special Interest (GPwSI) in substance misuse. This GP worked with the local community drugs team as part of a role with Derbyshire Healthcare NHS Foundation Trust to monitor and prescribe for patients with a substance misuse problem. This service was provided from the practice each week and was available to all patients, including those registered with other GP practices. This improved access for local residents who otherwise would have had to travel some distance to receive this service. The GP also monitored a small number of practice patients with substance misuse difficulties through the routine appointments service.
- Patients could order repeat prescriptions on line. The practice participated in the electronic prescription service, enabling patients to collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- All of the consulting rooms were accessed on the ground floor. The site was accessible for patients with reduced mobility, and there was access to a hearing loop system within reception and one of the GP consulting rooms for patients with a hearing impairment. The premises had been designed to comply with the Equality Act including lower access to the reception desk for wheelchair users.
- The practice provided a range of services that ensured these were easily accessible for their patients. This included phlebotomy (taking blood); ECGs to test the heart's rhythm; 24 hour blood pressure monitoring; spirometry (a test to assess breathing); travel vaccinations; and performed some limited minor surgery including joint injections.
- The waiting area contained a good range of information on local services and support groups. This included information for carers, support with bereavement, and local services available for patients with mental health issues. Health promotion material was displayed within the waiting area.
- Clinicians would print out specific information for patients to help them manage their condition, for example, an information and exercise leaflet for back pain.
- Telephone consultations could be arranged if required. These were useful for some local residents who would commute to areas including Manchester for their work.
- A text reminder service was used to encourage patients to attend their appointments.
- A television screen was to be provided later in the year with CCG funding to display health information and advice.
- The practice hosted some services on site to facilitate better access for patients. This included a weekly Citizens Advice Bureau session; a monthly abdominal aortic aneurysm screening service; a fortnightly eye screening service for patients with diabetes; a leg ulcer clinic provided by the district nursing team; a hearing clinic; and an orthopaedic knee clinic. Patients could also access a private physiotherapy service on site.
- Same day appointments were available for children and those patients with medical problems that required them to be seen urgently. Longer appointments could be booked for those patients with more complex needs. Home visits were available for older patients and others with appropriate clinical needs which resulted in difficulty attending the practice.
- The practice provided care for residents at two local care homes for patients with a learning disability. The community matron visited these homes each week, and any patients with urgent needs would receive a visit from a GP. Staff at the homes informed us they were very satisfied with the service provided, and described it as being responsive to their residents' needs. On occasions, if patients were taken to the surgery, the practice would be more flexible with times and lengths of appointments in recognition of their particular needs.
- Patients could be moved into a private room besides the main reception desk for confidential discussions.
- Translation services were available for patients whose first language was not English.

Access to the service

Are services responsive to people's needs?

(for example, to feedback?)

The practice's main site opened daily from 8am until 6.30pm. The practice closed on one Wednesday afternoon each month for staff training.

Scheduled GP morning appointments times at the main site varied each day depending on which doctor was working. GP consultations commenced in the morning from between 8.30am-9.30am until 11am-11.30am. Afternoon GP surgeries were provided starting from 2.50pm-4pm until 5-6pm, varying according to the GP who was on duty each day. GP appointments at the branch surgery were offered on Tuesday, Thursday and Friday mornings and on Thursday afternoons.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was significantly better than local and national averages.

- 91% of patients usually got to see or speak to their preferred GP, which was significantly higher than the CCG average of 60% and national average of 59%.
- 98% of patients found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 97% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 88% and a national average of 85%.
- 92% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.

The practice had achieved successful access without any specific systems in place such as embargoed appointments or a triage service. Staff informed us that patients could book in advance to see a GP or a nurse with the only restriction being when future appointments had been added onto their IT system. On the day of our inspection, we saw that the next available routine GP appointment was available that day, and several appointments were free for the rest of the week. This was despite the fact that the inspection took place on a Monday, a day which often experiences high demand for appointments following the weekend. In addition, one of the GP partners did not work on a Monday and the salaried GP was on annual leave. Patients we spoke with on the day of the inspection were extremely positive about their experience in obtaining an

appointment. Feedback received on comment cards expressed satisfaction with the appointment system, and patients said they could obtain an appointment on the day when they needed one. However, two comment cards included a negative comment that the patient had needed to wait to get an appointment.

The practice did not offer any extended hours consultations. This had been trialled but the uptake had not been sufficient to warrant its continuation, and the service was also difficult to support with a small team of GPs. There had been no adverse patient feedback regarding the lack of extended hours provision. The practice were keeping this under review and would re-assess the need periodically.

Appointments to see the practice nurse were usually available within a week. The practice employed one practice nurse which limited the range of appointments to some degree, however we observed that access for patients was still responsive to their needs.

Listening and learning from concerns and complaints

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

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

We looked at four complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. The practice offered to meet with complainants to discuss their concerns whenever appropriate. Lessons were learnt and shared with the team following concerns and complaints, and action was taken to as a result to improve the quality of care. For example, the practice had issued each newly diagnosed patient with a long-term condition with a schedule of monitoring, including the intervals at which they must be reviewed, and by whom, and in which order. This was done in response to a complaint from a patient stating they were unaware of how the recall system worked and why annual monitoring was important.

Are services well-led?

Good 

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

Our findings

Vision and strategy

- The service had produced a statement of intent that acted as the practice values. This included reference to the delivery of a quality service; involving patients in decision making about their treatment; and promoting good health through education and information.
- The practice held a partners' meeting with the practice manager twice each week. This informally reviewed key issues relating to the practice business, so these meetings were not documented.
- Whilst the practice did not have a written business plan, the partners had a clear vision for the future which they were able to articulate during our inspection. For example, the partners had aspirations to develop their site in accordance with the local CCG strategy for 21st century care. This would enable the practice to provide or host more services in the premises meaning that care could be provided closer to home for patients. The building held the potential for development as the upper floor space was not in use at the time of our inspection.
- The practice team had reviewed their strengths collectively at a protected learning time event and produced a list of 'what makes us different'. This reflected the practice's core values and a focus upon personalised care.
- The practice worked with other local GP practices, and was part of a local GP federation although this was not active at the time of our inspection.

Governance arrangements

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

- There was a clear team structure in place, and staff were aware of their own roles and responsibilities. All three GPs and nurses had defined lead clinical areas of responsibility.
- Systems were mostly in place for identifying, recording and managing risk, and implementing mitigating actions. However, the practice needed to ensure all risk areas were identified with a supporting risk assessment or management plan. This included the control of legionella and the absence of a practice defibrillator.

- A range of practice specific policies had been implemented, and were available to all staff.
- An understanding of the performance of the practice was maintained which included the analysis and benchmarking of QOF performance, and referral and prescribing data. Actions were undertaken when any variances were identified.

Leadership and culture

- Due to the distance of the practice's location from the CCG headquarters, the practice was fairly self-contained but they did engage with their CCG and worked with them to enhance patient care and experience. One partner attended the locality meetings with other local GP practices and CCG representatives. The practice manager periodically attended the local practice managers' meetings, and the community matron had established support networks with others for her matron role and management of the INR service.
- The partners and practice management demonstrated they had the experience and capability to run the practice effectively to ensure high quality care.
- Staff told us there was an open culture within the practice and said the partners and practice manager were approachable, and always took the time to listen to all members of staff. Staff said they felt respected, valued and supported by the partners and managers in the practice.
- Staff told us the practice held monthly meetings during their allocated protected learning time. They had the opportunity to raise any issues at these meetings and felt confident and supported in doing so. The team would meet together and use this as an opportunity to review incidents and also participate in mandatory or other general training applicable to the whole team. The team would then split into clinical and administration staff meetings to focus on issues particular to their own needs. Minutes from this meeting were documented.
- Staff we spoke with told us that the practice was a good place to work, and the team supported each other to complete tasks. The staff met outside of work occasionally for social events and the practice had combined a member of staff leaving with a sausage-making team building exercise. There was a low turnover of staff at the practice and many members of the team had worked there for some years.
- The practice had established some links with their local community. This included a textile art display in the

Are services well-led?

Good 

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

waiting area which had been created by a charitable organisation working with residents at homes for older people, and people with a learning disability. The practice had also developed links with some local schools and nurseries.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through patient surveys and on the NHS Choices website; via complaints received; a suggestion box; and responses received as part of the Families and Friends Test (FFT). The FFT is a simple feedback card introduced in 2013 to assess how satisfied patients are with the care they received. We saw that 95% of 177 patients who had completed a FFT card in the last 18 months said they were 'extremely likely' or 'likely' to recommend the practice to others. The practice was not routinely providing feedback to patients on the outcomes from the FFT, as they had not found any indication that patients wanted to see anything done differently. In response to this, the practice had tried to actively promote their suggestion box in an attempt to engage patients to highlight issues that would improve the service from their perspective.
- The practice did not have an active patient participation group (PPG) at the time of our inspection. The practice had placed an advertisement on a PPG noticeboard in reception to try to recruit patients in communicating feedback via e-mail.
- The practice had previously undertaken patient experience surveys. We spoke with a patient who was pleased that the practice had replaced a previous

premium-rate telephone line with a local number. This had been instigated further to an in-house patient survey and subsequent discussion with the PPG which was active at that particular time. We saw that a recent patient survey had been completed for the practice's INR service, and this demonstrated a high-level of service user satisfaction.

- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

The practice had a vision to develop their premises to be able to deliver the CCG strategy, and was engaging with them to try to achieve their aspirations.

The practice had approached a hospital specialising in the care of patients with cancer to see if they could provide phlebotomy and chemotherapy services at the practice. Patients were travelling up to 20 miles to access this service and the practice wished to provide this from their building for all patients residing locally, not just their own registered patients. This was in alignment with the CCG strategy of helping patients access services closer to home. It was hoped that the phlebotomy element of the service would commence within the next few months. The chemotherapy provision was subject to a wider premises development bid.

The practice was exploring new ways of providing services and had submitted a bid to develop a Skype consultation room as part of a potential premise development. This would benefit some of their patients who commuted to work in Stockport or Manchester, and would provide a more detailed consultation than a routine telephone appointment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|--|---|
| Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The provider was not doing all that was reasonably practicable to mitigate risks which had been identified. Specifically the provider was not doing all that was reasonably practicable to mitigate the identified risk of not having a defibrillator on the premises.</p> <p>This was in breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> |