The Arthur Medical Centre

Quality Report

Main Street,
Horsley Woodhouse,
Ilkeston,
Derbyshire
DE7 6AX
Tel: 01332 880249
Website: www.arthurmedicalcentre.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 1 December 2014 as part of our new comprehensive inspection programme. The practice is located at Main Street, Horsley Woodhouse, Ilkeston, Derbyshire DE7 6AX.

The overall rating for this practice is good. We found the practice to be good in all five domains: safe, effective, caring, responsive and well led. We found the practice provided good care to older people and families, children and young people, people with long-term conditions, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had very proactive systems in place in respect of medicines maximisation; employing two pharmacists, one of whom was a clinical pharmacist and an independent prescriber, able to see patients independently and in clinics. Two nurses were also independent prescribers with another undergoing training.
- There were systems in place to keep patients safe from the risk and spread of infection. Systems were in place to monitor and make required improvements to infection control at the practice.
- Patients were very satisfied with how they were treated and this was with compassion, dignity and respect. GPs and nurses were good at listening to patients and gave them enough time.
- Most patients reported they got an appointment when needed.
- GPs, nurses and clinical pharmacists were trained to meet a wide range of needs and the practice was very proactive at trying to prevent unplanned admissions to hospital. 2.69% of patients at risk of unplanned admissions had RightCare care plans; this was one of the highest rates in the CCG.

Summary of findings

- The practice had good means of communication with patients through a newsletter, website, and practice leaflets. It also had an active patient participation group that had contributed to positive improvements at the practice.
- The practice was well led and inclusive involving internal and external staff in the development of the service. There were whole team events and weekly meetings between the GPs, the registrars and the district nurses to discuss more challenging situations and promote effective multi-disciplinary working.

The provider should:

- Ensure all policies are reviewed and up to date

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice had a dedicated lead GP for safeguarding vulnerable adults and children, and staff had received training about abuse and safeguarding to a level appropriate to their role. The practice worked closely with the clinical pharmacists to ensure that patients' needs were met in a timely manner, without the need to always see a GP or nurse if this was not necessary. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. People's 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 have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. For example if a patient was diagnosed as needing palliative care the practice had a policy where they could choose the lead GP for their care. They chose a 'buddy' a second GP who would take over if the lead GP was not available. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had a walking group for patients. The group had been set up by members of the patient participation group (PPG) with the support of the practice. The walking group had promoted health and social integration for the group members.

Most patients reported they got an appointment when needed. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

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

The practice had a clear vision and strategy. The practice was open to comments and feedback from its patients and engaged with its patient participation group PPG to improve the services provided.

Staff were clear about the vision and their responsibilities in relation to the practice's vision and strategy. There was a clear leadership structure and staff felt supported by management, with the opportunity to comment and contribute.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and had established good systems for gathering feedback from its patients. For example we saw minutes of a meeting with a local care home and a care home questionnaire looking at how the practice could offer a better service to those patients living in a care home.

Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients aged 75 and over had a named GP, and were offered an appointment the same day if they needed one. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Home visits were made to three local care homes and to those patients who needed one. We spoke with senior staff at all three care homes who said the practice was supportive, and that there were no problems with accessing GP services for their residents.

People with long term conditions

Good

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

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits for patients with long-term conditions were available when needed. All these patients had a named GP and a structured annual review to check that their health needs were being met and the medicines they were prescribed were suitable and appropriate. The dispensary manager and the clinical pharmacist were actively involved in medicines reviews for patients at the practice. This included patients with long-term conditions and learning disabilities. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. For example 95.1% of 2 year old patients had the Measles, Mumps and Rubella (MMR) vaccine while the CCG

Summary of findings

average was 94.6%. 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. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included opening the practice on a Saturday morning for pre-booked appointments which suited patients of working age. The practice offered NHS Health Checks to all its patients aged 40 to 75 years, and any concerns were followed up within two weeks. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

We discussed patients whose circumstances may make them vulnerable with the reception staff. Staff were aware of patient's needs and gave examples of patients who found the waiting room difficult. The staff offered an alternative waiting area to make the patients more comfortable.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice carried out annual health reviews for patients who had poor mental health and/ or dementia. The health reviews included a medicines review by the dispensary staff.

Staff responded effectively to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice had support from a psychiatrist who visited the practice, and had links to improving access to psychological therapies (IAPT). IAPT is an NHS programme offering talking therapies to people with depression and anxiety disorders.

The practice had made information available to patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND (an organisation that provides advice and support to people experiencing poor mental health and their families.

There was a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health to ensure their safety and wellbeing.

Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 26 completed comment cards. All 26 had positive comments, expressing views that the practice offered an excellent service with understating, caring and compassionate staff, and committed, caring GPs. There were five cards which included negative comments. Two said that appointments did not always run to time, and patients often had a long wait for their appointment. However, several comment cards made reference to the GPs taking their time and patients not feeling rushed. Two other negative comments related to opening times, and the fifth commented on delays in getting a diagnosis.

The practice had conducted a patient survey through their patient participation group. The data collected related to a two month period from November 2013 to January 2014. 73% said that they had a good understanding of the appointment system. However, 58% indicated that they would appreciate fuller information on this and on the services that different types of clinical staff provided. In addition the national GP survey dated May 2014 showed that 128 patients had taken part.

Comments were very positive, with 88% of patients who responded described their experience of making an appointment as good, 97% had confidence and trust in the last GP they saw or spoke to and 92% described their overall experience of this surgery as good.

We spoke with five patients during our inspection. All five patients said they were happy with the care they received, and all five thought the staff were all professional, approachable, and caring. Most patients reported they got an appointment when needed.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The main one being that the practice had produced a practice leaflet that described "How to get the most from your GP Surgery." This leaflet gave more information to patients, and explained how the practice could help the patient and the patient could help the practice. A member of staff said that better communication between patients and the practice was key to improving the quality.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all policies are reviewed and up to date

The Arthur Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) inspector. The lead inspector was accompanied by a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to The Arthur Medical Centre

Arthur Medical Centre provides primary medical care services to approximately 8,250 patients. The practice is based in a building close to the centre of Horsley Woodhouse.

The practice offers a dispensary service, and the dispensary is open similar hours to the GP practice.

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract for the practice to deliver primary care services to the local community or communities.

There are six GPs at the practice and all are partners. The practice is a training practice with three doctors in training; all are GP registrars. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine**.** There are four male GPs and five female GPs including the doctors in training. In addition the nursing team comprises of six practice nurses and one healthcare assistant. The clinical team is supported by a clinical pharmacist in addition to the practice manager and an administrative team.

Arthur Medical Centre has opted out of providing out-of-hours services to its own patients. Out-of-hours services are provided by Derbyshire Health United through the 111 telephone number.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

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?

Detailed findings

- Is it well-led?

We 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 hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 1 December 2014. During our visit we spoke with a range of staff (GPs, nursing staff and administration and reception staff) and spoke with five patients. We observed how people were being cared for and talked with patients. We reviewed 26 comment cards.

Good

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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw completed incident forms and the last recorded accident which had been in January 2012. This related to a needle stick injury, and the records showed the accident had been dealt with in line with both the accident policy and the needle stick injury policy.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Minutes of meetings showed that the practice held regular health and safety meetings, where issues were discussed and action points recorded.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last five years, although we concentrated on the records from the last two years. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. 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. Practice records showed there had been 18 significant events in the past two years. The records clearly identified the learning points from each significant event and reflected the discussion that had taken place.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. He showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example a person's health deteriorated whilst they were in a consulting room. The GP pressed the panic alarm; however staff were slow to respond. As a result the policy for using and responding to the panic alarm was reviewed and updated. Learning points were discussed at the practice meeting and it was agreed to run practice panic alarm drills. A similar incident happened soon after, with a quick response from reception staff which demonstrated the review had been effective.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff, having first been assessed as to their relevance to each person's job role. In addition records showed that staff carried out a weekly visual health and safety check of the premises to ensure there were no potential risks.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training in 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. They were 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.

The practice had a dedicated GP as the lead 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. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients

attended appointments; for example children subject to child protection plans. The practice held monthly meetings with the health visitor, school nurse and safeguarding lead to discuss any families or children on the at risk register.

GPs were appropriately using the required codes on patients' 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. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

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, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. However, the policy did not make it clear where to stand, and this was raised with the practice manager during the inspection. The practice manager said the policy would be reviewed now that this issue had been highlighted.

Medicines management

The practice had very proactive systems in place in respect of medicines maximisation; employing two pharmacists, one of whom was a clinical pharmacist and an independent prescriber, able to see patients independently and in clinics. Two nurses were also independent prescribers with another undergoing training.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. There were copies of both sets of directions and nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice could access the advice of the clinical pharmacist and dispensary staff who worked on site and supported practice staff by monitoring the prescribing of medicines and dispensing rates.

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 using their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for patients to pick up their dispensed prescriptions at the practice and had systems in place to monitor how these medicines were collected. They had arrangements in place to ensure that patients collecting medicines from the practice were given all the relevant information they required from the dispensary staff.

Patients were able to discuss their medicines with the clinical pharmacist in private. The clinical pharmacist was able to prescribe certain medicines and worked closely with the GPs and nurses particularly with patients who had long-term conditions. As part of the clinical pharmacist's role they worked closely with the National Institute for Health and Care Excellence (NICE) pharmacy team. As a result the latest guidance and best practice was quickly available to the practice, with the clinical pharmacist able to give informed advice and guidance.

Good

Are services safe?

We were shown an analysis of prescribing data dated August 2014. This compared data from the practice with other local practices and the Clinical Commissioning Group (CCG) as a whole. The data identified that the practice was doing as well or better in most areas of prescribing than the other practices in the local area. This included being the lowest in the CCG for the proportion of high dose protein pump inhibitors prescribed. Protein pump inhibitors are a group of medicines that reduce the production of gastric acid. There are a number of side effects associated with these medicines, and with their long term use, therefore low prescribing rates are recommended.

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 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. Staff were aware of the requirements and obligations in respect of infection control. All staff received induction training about infection control specific to their role and received annual updates. The practice undertook audits in respect of cleanliness and infection control and the findings were shared at three monthly health & safety meetings and at the GP and nurses meetings at the practice. Minutes of those meetings confirmed this.

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. We saw that new staff were given leaflets about infection control during their induction as well as an information pack relating to hand hygiene and dealing with spillages. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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 equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometers. Practice records showed that the practice had systems and procedures in place to monitor and check the equipment in use at the practice.

Staffing and recruitment

There was a robust system in place for the recruitment of staff. Staff files we looked at contained evidence to demonstrate that appropriate recruitment checks had been undertaken prior to employment. For example, 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 and our evidence indicated this was followed in practice.

The arrangements for ensuring there were sufficient staff available to meet patients' needs were robust. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff we spoke with told us that the practice rarely used locum GPs. They told us they preferred to use doctors who had been placed with them whilst they were training who were aware of the systems and policies at the practice.

Staff told us there were enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

Good

Are services safe?

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly health and safety checks in respect of (for example) the building, the environment, and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

There were emergency processes in place for patients with long-term conditions. These included being seen by the dispensary staff. Patients with long-term conditions whose health deteriorated suddenly would be seen by a GP, and referred on to secondary care if appropriate. Similar emergency processes were in place for identifying acutely ill children and young people.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice had support from a psychiatrist who visited the practice, and had links to improving access to psychological therapies (IAPT). IAPT is an NHS programme offering talking therapies approved by NICE for treating people with depression and anxiety disorders.

The practice had made information available to patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. Discussions with a GP identified that there was a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records we saw confirmed that it was checked regularly.

The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately. The review showed that there had been an appropriate referral to secondary care and changes to practice included all staff learning about the potential side effects of the patient's medicine to alert them to and patient care had improved as a result.

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 and hypoglycaemia

(heart attack, allergic reaction and low blood sugar). We were assured that a full risk assessment had been undertaken and a protocol was in place to manage patients with other conditions who may need other treatments with staff instructed to dial 999 for an ambulance if required. Processes were 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. The document contained relevant contact details for staff to refer to. For example, there was a memorandum of agreement with other local practices to share resources in the event of the practice not being available due to a power failure or some other problem or issue with the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

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.

The staff we spoke with and the evidence we reviewed confirmed that clinical staff used QOF templates to ensure that each patient received support to achieve the best health outcome for them. Staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Our review of the clinical meeting minutes confirmed that this happened.

The practice staff showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was better to similar practices in the local area. The data identified that the average cost per item was the lowest in the CCG. This indicated that medicines were managed and reviewed effectively at the practice.

The practice used computerised tools to identify and flag patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards and NICE guidelines. For example patients being seen at the out-of-hours service or at the accident and emergency department with asthma symptoms were seen within three days by their GP for an asthma review. The NICE guidelines state 50% of patients in such circumstances should be seen within two days and 100% should be seen within 30 days. The practice was able to demonstrate that it achieved both. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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, ethnicity 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.

The practice showed us eight clinical audits that had been undertaken in the last year. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

For example, an audit was undertaken in respect of the prescribing of a medicine used to treat problems with the heart rhythm. Guidance from the Derbyshire Joint Area Prescribing Committee (JAPC) provided clear instructions regarding initiation and monitoring of this medicine. Following the initial audit the practice had continued to monitor and review patients prescribed the medicine. This ensured patients had the appropriate recalls set up for monitoring of the medicine and ensuring it was effective. GPs were aware and alert for any possible interactions with this medicine when prescribing for patients.

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).

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 84% of patients diagnosed with diabetes had received an annual retinal eye examination, and 93.8% of patients diagnosed with diabetes had an annual appointment with a chiropodist for a foot examination in line with NICE guidelines. This practice was not identified as performing outside of the expected range for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly

Good

Are services effective?

(for example, treatment is effective)

checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines, and the clinical pharmacist was available for advice and guidance when needed. We saw evidence to confirm 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. Discussions with both GPs and the clinical pharmacist identified that they would both be involved in those discussions. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice were working towards the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice participated in local benchmarking run by the Clinical Commissioning Group (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 comparable to other services in the area. For example chronic kidney disease, coronary heart disease and asthma.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with courses the practice had identified as ones which staff must undertake such as annual basic life support. We noted a good skill mix among the doctors with a number having additional diplomas. For example in; sexual and reproductive medicine, in children's health and obstetrics, a post graduate diploma in sport and exercise medicine and a diploma from the faculty of family planning. Three of the partner GPs performed minor surgery at the practice.

All of the GPs were up to date with their yearly continuing professional development requirements and all had either 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.

Working with colleagues and other services

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 protocol outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well and the evidence we observed confirmed this was the case.

The practice was commissioned for the new 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 hospital communications was working well, and staff gave examples of how the practice had communicated with the local hospital particularly in respect of older or vulnerable patients.

The practice was very proactive at trying to prevent unplanned admissions to hospital. 2.69% of patients at risk of unplanned admissions had RightCare care plans; this was one of the highest rates in the CCG.

The practice undertook a yearly audit of follow-up appointments to ensure inappropriate follow-ups were documented and that no follow-ups were missed. The

Good

Are services effective?

(for example, treatment is effective)

practice manager said that the practice had a robust review appointment system for the various clinics particularly for patients with long-term conditions such as diabetes and asthma.

The practice held multidisciplinary team meetings on a weekly basis to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record on the Intradoc system. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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. Electronic systems were in place for making referrals, and the practice made 1365 referrals last year 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 emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has signed up to the electronic Summary Care Record and this was fully operational when we inspected. (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 SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented that the system was easy to use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004. 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. There was a policy in place in respect of consent to treatment.

The whole practice team had received training from an independent mental capacity advocate (IMCA). 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. The policy was available to all staff on the internal electronic records system.

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 where possible. 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 decisions.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). There was guidance on the sexual health template used by clinicians prompting them to consider both Gillick competencies and Fraser guidelines.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed in 90% of cases, with verbal consent being obtained in the other cases.

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

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

Good

Are services effective?

(for example, treatment is effective)

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous 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 smoking cessation advice to these patients through the on-site dispensary service. Evidence from the Derbyshire County stop smoking service identified that 67% of patients identified by the practice as smokers had stopped smoking. The dispensary therefore received a £600 bonus payment from Derbyshire County Council as a result; one of only five pharmacies in Derbyshire to achieve this.

The practice's performance for cervical smear uptake was 81.7% which was better than the national average (76.9%). There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We saw data that showed the immunisation rates for all standard Immunisations were above the CCG average. For example 95.1% of 2 year old patients had the Measles, Mumps and Rubella (MMR) vaccine while the CCG average was 94.6%. There was a clear policy for following up non-attenders by the named practice nurse.

Discussions with the dispensary manager and clinical pharmacist identified that they were actively involved in medicines reviews for patients at the practice. This included patients with long-term conditions and learning disabilities.

All patients aged over 75 years had a named GP and could be seen on the same day they made an appointment. Patients in vulnerable circumstances had care plans and the practice took a multi-disciplinary approach to caring for those patients identified as being vulnerable. This was evidenced in the minutes of meetings we saw.

There were no specific support groups within the practice however; there was evidence of signposting patients to various support groups such as the 'Take a break' carer's service in Derbyshire and Talking mental health Derbyshire.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from 2014 and a survey of patients undertaken by the practice's patient participation group (PPG). The evidence from both these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect.

For example, data from the national patient survey in 2014 which had 128 responses, showed 92% of respondents described their overall experience of this practice as good. The practice was above average for its satisfaction scores on consultations with doctors and nurses with 97% of practice respondents saying the GP was good at listening to them and 93% saying the GP gave them enough time, 94% said the last nurse they saw gave them enough time and 91% said the last nurse they saw was good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and every one contained positive comments about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five comments contained some less positive comments but there were no common themes to these.

We spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. All five patients gave examples of how they had been treated well by the practice and they rated the practice as excellent.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The waiting room was small and it was possible to hear what was said at the reception desk. Staff were aware of this, and a private room was available if required. Staff at the practice commented on the limitations within the building, and outlined plans to move to new premises. Improvements with regard to the waiting room and reception area would be a major benefit. Staff played music into the waiting room to provide a distraction from the conversation at the reception desk. This helped prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled some confidentiality to be maintained.

We discussed patients whose circumstances may make them vulnerable with the reception staff. Staff were aware of patient's needs and gave examples of patients who found the waiting room difficult. The staff had offered an alternative waiting area to make the patients more comfortable.

Care planning and involvement in decisions about care and treatment

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, data from the 2014 national patient survey showed 88% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. Both these results were above average compared to the local CCG area.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was positive and aligned with these views.

When a patient was diagnosed as needing palliative care the practice had a policy where they could choose the lead

Good

Are services caring?

GP for their care. They chose a 'buddy' a second GP who would take over if the lead GP was not available. We did not meet any patients with experience of this, however a member of staff said that patients had been appreciative and liked that their care had become more personal.

Staff told us that translation services were available for patients who did not have English as a first language. However, the practice said there were very few patients who this applied to. The practice website had a translate page, which converted information into one of 90 different languages.

We saw notices and leaflets in the reception areas informing patents of a wide range of local health services that were available. The website carried information about a range of health issues and conditions.

Patient/carer support to cope emotionally with care and treatment

The national patient survey data from 2014 showed patients were positive about the practice with 90% saying they would recommend the practice to someone new to the area.

Notices in the patient waiting room, on the TV screen and patient website told patients how to access a number of support groups and organisations. 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 practice had established a carer's support group through the Patient Participation group (PPG). This group had become independent of the practice over time, and was linked to Carers Direct a caring organisation run through the NHS. This enabled carers at the practice to be signposted to receive more support.

Staff told us that if families had experienced bereavement, their usual GP contacted them and offered a bereavement visit. This visit was 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.

The practice had established good systems for supporting its patients. For example we saw minutes of a meeting with a local care home and a care home questionnaire looking at how the practice could offer a better service to those patients living in a care home.

Patients with who might require a blood test for hypertension (high blood pressure) were given a leaflet explaining they would need to provide both a blood and urine sample, they would need two appointments and how long those appointments would take. This had been in response to patients being unprepared to provide two samples and unaware they would need a second appointment. This had resulted in these appointments being more effectively organised and patients told us they were happier as they had been informed what was required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The main one being that the practice had produced a practice leaflet that described "How to get the most from your GP Surgery." This leaflet gave more information to patients, and explained how the practice could help the patient and the patient could help the practice. A member of staff said that better communication between patients and the practice was key to improving the quality.

The practice had a patient participation group (PPG). In the past the PPG had been instrumental in setting up a walking group for patients. The group walk in the local area and this had promoted health and social integration for the participants. Details of the walking groups were on the website. Members of the PPG said they thought that the walking group offered a helpful resource to the practice. A GP said that for some patients who required some gentle exercise the walking group offered the perfect solution, as it was local, regular and not too strenuous.

The website made reference to the Citizen's Advice Bureau (CAB) holding sessions at the practice every Tuesday afternoon. There was information on how to make an appointment with the CAB.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. This included patients with a learning disability, those living care homes and carers providing care to a family member of friend.

The practice had access to online and telephone translation services which were accessed during the patient consultation.

Staff at the practice said they were limited by the building. As a result the practice with the support of the patient participation group was actively looking to move to new premises which would better suit the needs of the staff and patients.

The practice had a population of 97% English speaking patients though it could cater for other different languages through translation services.

Access to the service

82% of patients who responded to the national patient survey from 2014 who said they were satisfied with the practice's opening hours. 91% of patients who responded said it was easy to get through to the practice by telephone, 98% of patients who responded said their last appointment was convenient. Most patients reported they got an appointment when needed.

Appointments were available from 08:00 am to 13:00 pm and 15:10pm to 18:10 pm on weekdays, and 08:00 am to 12:15 pm on Saturdays. The Saturday sessions were exclusively for pre-booked appointments and were particularly useful to patients with work commitments. The practice closed one Wednesday afternoon per month for staff training.

Information about how to make an appointments system was available in the practice, in the practice newsletter and on the practice's website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Home visits and longer appointments were available for patients who needed them and those with long-term conditions. This included appointments with a named GP or nurse. Home visits were made to three local care homes and to those patients who needed one. We spoke with senior staff at all three care homes who said the practice was supportive, and that there were no problems with accessing GP services for their residents.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were available outside of school hours for children and young people. There was an online booking system and repeat prescription service available.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There were posters displayed in the waiting room and a leaflet explaining how to make a complaint available at reception. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. The correspondence we saw showed that the practice had been open and transparent in dealing with the complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. We saw that one complaint had been managed as a significant event, one related to clinical care and treatment. In each case the complainant had been contacted and made aware of the action taken. Where necessary an apology was given.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's values were bound in a mission statement which had holistic care of the patients as its fundamental belief. We spoke with several staff members who were able to describe the practice's values.

A copy of the practice charter which outlined the patient's rights and the commitment from the practice was available on the practice website.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at nine of these policies and procedures and found most had been reviewed and updated within the last two years.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit of patients with gout (an inflammation of the joints usually in the lower legs).

The practice had arrangements for identifying, recording and managing risks. There were risk assessments in place for the environment and clinical activity. We saw that risks were regularly discussed at team meetings; risk assessments had been carried out where necessary and action plans had been produced and implemented to mitigate against these and ensure patient and staff safety.

The practice held monthly governance meetings. We looked at minutes from the last two meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and the induction policy which were in place to support staff. We were shown that policies were available to all staff including equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice was well led and inclusive involving internal and external staff in the development of the service. There were whole team events and weekly meetings between the GPs, the registrars and the district nurses to discuss more challenging situations and promote effective multi-disciplinary working.

The practice had gathered feedback from patients through patient surveys and complaints received. The main challenge identified by both the GPs and the PPG to the delivery of high quality patient care was the limitations imposed by the building. The practice was actively looking to extend the building, and this was being done with the full backing of the PPG.

The practice had an active patient participation group (PPG). The PPG was formed in 2005 and met approximately ten times a year. The PPG has approximately ten members, in addition there is a virtual group who are contacted via e mail. The virtual group known as the Patient Reference Group PRG) numbered several hundred. The PPG had an annual general meeting and has sent a representative to the PPG national conference. A senior member of the practice staff regularly attended PPG meetings and gave feedback at practice meetings.

Are services well-led?

Good

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

The PPG had carried out a satisfaction survey at the practice. 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.

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. Several members of staff said that there was an open culture and staff were able to raise issues for discussion at practice meetings.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan.

The practice was a GP training practice for GP Registrars (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine). All GP partners were responsible for the induction and overseeing of the training for GP Registrars.

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. For example a patient was found to have particular condition. This was discussed at the practice meeting to increase awareness among clinical staff regarding this condition which often had a delayed diagnosis as standard tests were prone to give a normal result.