Tideswell Surgery

Inspection report

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Tideswell
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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 location	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Good** ●

Overall summary

This practice is rated as 'Outstanding' overall.

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Good

We carried out an announced comprehensive inspection at Tideswell Surgery on 3 September 2018. This inspection was undertaken following the practice's merger with Bakewell Medical Centre in 2017. The registered provider for regulated activities at these two locations is the Peak and Dales Medical Partnership.

The provider's registration with the Care Quality Commission (CQC) was updated on 3 October 2017 to reflect the new arrangements. The inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions to check whether the provider was 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.

At this inspection we found:

- People were truly respected and valued as individuals and were empowered as partners in their care. We found compelling evidence to support that the service was centred towards the needs of patients and the delivery of first class care. This was supported by the 2018 national GP patient survey in which Tideswell Surgery performed higher on all 18 questions compared to local and national averages, in some cases by a significant margin. Eleven of the 18 questions scored either 99% or 100% satisfaction scores. This was further demonstrated by the feedback received in the 50 comments cards we received from patients on the day of the inspection, all of which provided highly positive patient experiences regarding the practice.
- Services were tailored to meet the needs of individual people and delivered in a way to ensure flexibility, choice, and continuity of care. Patients had on-the-day access to see a GP. A daily 'drop-in' clinic ensured that all patients got to see a GP if they wanted to see one. The access indicators used by the CQC in the accompanying evidence table show all measures are a positive or significantly positive variation to local and national averages
- The practice provided a weekly medicines delivery service to a 'branch location' at Taddington. This was maintained in recognition of the difficulties caused by rural isolation, which could often prove difficult for example, for those who worked in the farming community. An informal surgery was held between 12.30pm-1pm each week to ensure patients had access to a medical consultation and basic health checks if required. Any patients requiring follow up tests or investigations would be directed to the Tideswell site.
- The partnership had undertaken significant work to integrate elements of the two practices since the merger had taken place, and had invested in a project manager to support this process. They had ensured continuity in delivering quality services throughout this period. There had been a commitment to maintaining each practice's own identity to reflect the needs of their own communities.
- Joined-up working with Bakewell Medical Centre meant there was greater flexibility and capacity for GP clinical sessions, and staff such as the practice-based pharmacist, offered more care options for patients.
- The practice strove to maintain integrated care for their patients within a rural location, and accommodated a number of visiting services and professionals including health visitors, midwives, podiatrists, physiotherapists, counsellors and the Citizens Advice Bureau.
- The provider had an achievement of 95% in the 2017-18 Quality and Outcomes Framework (QOF), which was a slight reduction from the previous year. These figures remained subject to external verification. We saw that the levels of exception reporting were below local and national averages showing that patients engaged well with the practice to monitor and improve their conditions.
- We found effective systems were in place to promote adult and child safeguarding.
- People were protected by an established safety system, supported by a focus on openness, transparency, and learning when things went wrong.
- Environmental risk assessments had been undertaken, including fire and Legionella.
- The practice ensured that care and treatment was delivered according to evidence-based guidelines.

Overall summary

- Processes within the dispensary mostly kept patients safe. Medicines and patient safety alerts were managed effectively and there were processes in place to be assured of the competence of staff.
- The practice encouraged learning and improvement, and we saw that staff were mostly up to date with the practice's training schedule. The practice was not able to easily demonstrate up-to-date evidence for GPs, although we were told this had been completed.

We found three areas of outstanding practice:

- Outcomes for people who use services were consistently better than expected when compared with other similar services. For example, in addition to the results in the GP patient survey, the practice performed above local and national averages in relation to cancer screening and child immunisation rates. There were lower attendance rates for Accident and Emergency attendance (the third lowest of 50 practices across the two local CCGs), and emergency hospital admissions (the sixth lowest of the 50). This demonstrated a strong commitment to working in partnership with their patients.
- The practice participated in a local project called 'Train the Trainer' to improve the quality and impact of health reviews through effective information sharing between appropriate health care professionals. They were able to provide examples to demonstrate the effectiveness of this. For example, a patient was intending to stop their medicines and explained their reasons for this. This led to an urgent referral for the consultant to review the patient and advise them accordingly.
- Further to a project on health in rural communities, a health check facility had been arranged at a nearby agricultural centre to encourage opportunistic health screening and advice. A GP partner had been involved in the recruitment of a nurse to deliver this service.

There were also some areas where the provider **should** make improvements:

- Fridge temperature monitoring in the dispensary should be completed daily in line with the practice's own standard operating procedure.
- The practice should review their training log to consider incorporating a summary of GP training, in particular mandatory training attendance, as identified within the partnership's training policy.
- Review templates for significant events and errors to ensure these are signed off with a record of the actions taken, including dates of completion.

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

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a nurse specialist advisor, a member of the CQC medicines team, and a second CQC inspector.

Background to Tideswell Surgery

Tideswell Surgery is registered as a location with the CQC, with the provider of the service being the Peak and Dales Partnership. The partnership consists of four GPs (one male and three females), who have another registered location at Bakewell Medical Centre, approximately eight miles away. All four partners work across both practices.

Tideswell Surgery received a CQC inspection in October 2014 under the previous provider. At that inspection, it received an overall good rating, with an outstanding rating for being responsive.

The Peak and Dales Partnership became registered with the CQC as the provider for Tideswell Surgery in October 2017, following a merger with Bakewell Medical Centre. Bakewell Medical Centre received a comprehensive CQC inspection in May 2015 when the practice was rated as outstanding in all domains and population groups.

The practice is situated in Tideswell, which is a village in the Derbyshire Peak District, situated approximately seven miles east of Buxton. The surgery was built in 1973, and extended in 1997. It is a two-storey building, but all patient services are situated on the ground floor. It provides primary care medical services commissioned by NHS North Derbyshire CCG and NHS England, and offers dispensing services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy.

The practice has 3,322 registered patients. This has remained static since the practice's last inspection in 2014 due to restrictions on new builds in the area as it is within a national park. Patients are predominantly of white British origin, with only 0.9% of people within the practice area being from BME groups. There is a small Polish population, mainly employed though the local agricultural economy. The age profile of registered patients shows a higher percentage of patients aged over 65 compared to the national average at 23.7% compared to 17.1% The age profile is generally in line with CCG averages. The practice serves a population that is ranked in the second least deprived decile for deprivation, however there are pockets of local rural deprivation.

There are 14 staff based at Tideswell Surgery. However, other members of the team based at Bakewell also provide sessional input on site. Two female GPs (one GP partner and one salaried GP) are based at Tideswell, with six other GPs (three males, three females) working some sessions on site.

There is a practice nurse, who also works some hours as a community matron, and two other practice nurses from Bakewell also provide sessional input. There are two part-time health care assistants. A full-time pharmacist works across both practices and is the manager of the dispensary service at Tideswell.

A patient services manager heads a team of nine staff who work flexibly to cover reception, administrative and other duties. For example, a member of this team also works as a care coordinator and health care assistant. Seven of the administrative team are qualified to dispense medicines. The practice also employs a part-time dispensing technician.

Management across Tideswell Surgery and Bakewell Medical Centre is overseen by a full-time partnership manager, assisted by a project manager who leads on the integration programme.

Tideswell Surgery accommodates foundation year two GPs on site.

The practice opens from 8am until 6.30pm Monday to Friday, with extended hours opening on a Tuesday morning from 7.30am for appointments with the nurse, and on alternate Wednesdays and Thursdays until 8pm for GP consultations.

The surgery closes for one afternoon each month for staff training. When the practice is closed, patients are directed to Derbyshire Health United (DHU) out of hours via the 111-service.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. Staff had received up-to-date safeguarding training appropriate to their role. They knew how to identify and report safeguarding concerns.
- Staff who acted as chaperones were trained for their role and had received a 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).
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. An update on sepsis was arranged for the practice team in October 2018.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks. However, the practice needed to ensure adherence to their own Standard Operating Procedure for the monitoring of fridge temperatures within the dispensary.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The prescribing of antibiotics at the practice supported good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- Arrangements for dispensing medicines at the practice kept patients safe.
- There was a robust monitoring process for patients prescribed high risk medicines.
- A partnership-based pharmacist worked between both sites to offer support and advice on all issues relating to medicines management.

Track record on safety

The practice had a good track record on safety.

- There were risk assessments available in relation to safety issues.

Lessons learned and improvements made

Good

Are services safe?

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. GPs and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong and were reported. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. Learning was discussed at practice meetings and disseminated to the practice team. However, templates for significant events and errors were not always signed off with a record of the actions taken, including dates of completion.
- The practice acted on patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services.

Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.

Effective needs assessment, care and treatment

Clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Templates on the practice computer system linked with guidance to ensure care was provided in accordance with current evidence-based practice. Any new or revised guidance was discussed at regular clinical meetings, and all clinical staff received email correspondence about any new or updated guidance. GPs attended regular update courses and shared relevant information with the practice team.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received an assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients who were living with moderate or severe frailty. Those identified as being frail received an annual review including a review of their prescribed medicines by the practice pharmacist. Those with a higher level of needs were added to the community matron's caseload.
- The practice followed up on older patients who had been admitted to hospital and liaised with secondary colleagues throughout the admission, as well as when the patient was discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. A member of the team worked as a care coordinator to help facilitate this.
- The practice held regular multidisciplinary team (MDT) meetings with community-based health teams (for example, district nurses) and social care staff to discuss those patients with complex needs, including those at end-of-life. This ensured that all members of the MDT were involved in delivering the best possible holistic care to patients.
- The practice offered flu vaccinations and monitored uptake. Upon noticing a higher rate of flu refusals in 2016-17 at 18.5%, the practice proactively contacted patients to encourage uptake and reduced this to 14.1% in 2017-18. They continued to try and reduce this rate further to help keep vulnerable patients safe.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. Many patients would see both the nurse and GP as part of this annual review. For patients with the most complex needs, the practice team worked with other health and care professionals to deliver a coordinated package of care.
- The practice nurse had recently taken on additional responsibilities to incorporate the community matron role which had previously been undertaken by the local community healthcare provider. This provided greater continuity of care for patients, and allowed the practice to respond more quickly and appropriately when any issues arose.
- The practice had established effective working relationships with specialist nurses. For example, the community respiratory nurse undertook joint clinics with the practice nurse to review patients with more complex needs. Regular liaison took place with community based diabetes and heart failure specialist nurses.
- Outcomes achieved for long term conditions from the most recently published QOF data (2016-17) was 99.7% (CCG 99.2%; national 95.6%). The practice's own data for 2017-18 (subject to external verification) showed a slight decrease to 96.7%.
- The pharmacist assisted with medicines reviews and ensured the practice adhered to prescribing guidance by working with the CCG medicines management team. The pharmacist ensured any changes to prescribed medicines were addressed promptly following a hospital admission.
- There was an emphasis on patient empowerment to understand and self-manage their own condition. Care plans were completed in partnership with patients and shared with the out-of-hours' service.

Good

Are services effective?

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were significantly above the target percentage of 90% or above, and all of the indicators we reviewed were above the World Health Organisation (WHO) target of 95%. The practice had arrangements for following up failed attendance for immunisation appointments.
- MMR immunisation uptake was reviewed for teenagers, and a number of 16-year olds, whose parents had originally declined immunisations, were invited for a review and some had subsequently decided to be immunised.
- Teenage health was promoted via opportunistic health checks and information was provided on sexual health.
- The practice liaised regularly with health visitors, midwives and school nurses to deliver effective care to families.
- GPs attended safeguarding meetings with the health visitor and midwife. The minutes of these meetings were shared with the lead child safeguarding GP. Safeguarding was included on the agenda of all clinical meetings including GP, nurse and multi-disciplinary meetings.
- The practice adhered to national guidance on determining a younger person's capacity to consent when consulting with them (for example, contraceptive advice).

Working age people (including those recently retired and students):

- Guaranteed access to see a GP each day meant that practice patients were low users of the out-of-hours' service, the walk-in centre, and the Accident and Emergency department.
- The practice's uptake for cervical screening was 81.5%, which was in line with the 80% coverage target for the national screening programme. The practice had systems in place to check uptake and to recall non-responders.
- The practice's uptake for breast and bowel cancer screening was above local averages and national averages. Bowel cancer screening rates were over 10% higher than the national figure.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way and regular palliative care meetings were held which included the local Macmillan nurse. Patient deaths were reviewed to consider what had gone well in supporting a dignified death, and if care could be improved for patients in the future. The practice shared appropriate information with the out of hours provider to ensure the patient received the right care promptly, in line with their preferences.
- The practice held a register of patients with a learning disability and offered annual health checks to them. The practice was able to demonstrate that 10 patients (100% of those patients on their learning disability register) had received an annual review of their health needs in the last 12 months.
- Staff had received training and were aware of what to do, and who to contact, regarding adult safeguarding concerns. They were able to recognise signs of abuse, and staff were aware of the lead GP. Alerts were used on the practice computer system to ensure staff were aware of any concerns. We saw evidence that clinicians attended vulnerable adult review meetings to work as part of a wider team to help protect vulnerable individuals.

People experiencing poor mental health (including people with dementia):

- The practice participated in a local project called 'Train the Trainer' to improve the quality and impact of health reviews. They could provide examples to demonstrate the effectiveness of this. For example, a patient was intending to stop their medicines and explained their reasons for this. This led to an urgent referral for the consultant to review the patient and advise them accordingly. The project ensured stronger linkages between services to work together to deliver patient centred care, and promote better engagement with the patient to encourage access to health care.
- The practice assessed and monitored the physical health of people with poor mental health by providing access to health checks, interventions to promote

physical activity, and access to 'stop smoking' services. For example, a mental health patient with another long-term condition lost a significant amount of weight due to their engagement with the practice.

- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The practice was working to become a dementia-friendly practice at the time of our inspection with the support of their Patient Participation Group (PPG).
- QOF data from 2016-17 showed an achievement of 100% for mental health, and unverified data from the practice showed this had been maintained this in 2017-18. However, there was a higher level of exception reporting at 19% (CCG 12%; national 11%) in 2016-17, but this was due to the small number of patients on the register with a relatively high proportion being excepted due to having given informed dissent.
- Data showed the practice's prescribing of hypnotic medicines was half of the CCG average and less than half of the national average. There are known risks with long term use of these medicines and the low rates of prescribing helped to keep patients safe.
- A consultant psychiatrist delivered bespoke training on mental health to the practice team in 2017.
- Results from the 2018 national GP patient survey showed 100% of patients felt the healthcare professional recognised or understood any mental health needs during their last appointment (CCG average 91%; national average 87%).

Monitoring care and treatment

The practice provided some evidence of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- QOF results for 2016-17 showed an overall achievement of 99.7% compared to the CCG average of 99.2%, and a national average of 95.6%. The practice provided information (subject to external verification) that this performance had reduced slightly with an achievement of 95% for 2017-18. The practice explained that this was partly due to having no patients who fitted the criteria for inclusion on a cardiovascular primary prevention register, resulting in the loss of 10 points. In addition, the remaining lost points related to diabetes and the practice were aware of this and had taken action to address this with the support of the local medicines management team. This was showing an improved trend.
- The overall exception rate was below local and national averages at 4.3% (CCG 6.2%; national 5.7%). However, these were higher for mental health indicators at 19%.
- The practice was involved in quality improvement activity. For example, we saw some evidence of a clinical audit programme. One full cycle audit had been completed in the last 12 months in relation to British Thoracic Society guidance on the use of medicines to widen airways to help breathing. The second cycle showed that more patients were engaging with annual reviews and six-monthly medicines reviews, although there was scope to increase uptake further. The practice provided a summary of other quality improvement activity that had taken place, or was ongoing, within the practice.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Records of skills and qualifications were maintained, although training records required some updating to incorporate a record of GP training.
- The practice had an ethos of learning and continual development. Staff were encouraged and given opportunities to develop. Foundation Year 2 doctors working on site met with registrars and medical students working at the Bakewell site to enhance tutorials.
- The practice provided staff with ongoing support. This included an induction process, appraisals, clinical supervision and support for revalidation.
- There was a procedure in place for supporting and managing staff when their performance was poor or variable.

Good

Are services effective?

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- All appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients. They shared information with, and liaised, with community and social services for housebound patients and with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were admitted (and subsequently discharged) from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took account of the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, advice on stopping smoking and tackling obesity. Patients could access the Live Life Better Derbyshire scheme for ongoing support to live healthier lifestyles.
- The practice offered NHS health checks and new patient checks.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services caring?

We rated the practice as outstanding for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was overwhelmingly positive about the way staff treat people.
- Staff understood patients' personal, cultural and social needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids (for example, a hearing loop) and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The latest results from the national GP patient survey showed that patients felt that they were involved in decisions about their care and treatment. Results were above local and national averages.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as outstanding for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who have complex needs.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice hosted services on site including physiotherapy and podiatry to enable access to these services for those who resided locally.
- A range of patient information leaflets were available. This included ones developed by the partnership including how to use ear drops, discharge advice following minor surgery, and chronic kidney disease.
- Patient donations were used to purchase equipment to support patient care. This included a 24-hour blood pressure monitoring machine to help prevent the patient having to attend a hospital appointment.

Older people:

- The practice undertook home visits to patients unable to attend the surgery for acute medical problems as well as for chronic disease management. They also offered flu jabs to housebound patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with members of the wider local community health and social care teams to discuss and manage the needs of patients with complex medical issues.
- The practice offered home visits from a GP or the community matron as needed to meet the needs of this group when required. Longer appointment time could also be booked for patients attending the practice.
- Patients were referred to community programmes for advice on managing their condition, and promoting healthy lifestyles. This included the Live Life Better Derbyshire scheme, pulmonary rehabilitation, and education programmes for diabetes and pre-diabetes.
- A teaching session was arranged at a local day centre for patients with breathing difficulties. This was to be led by the practice nurse and respiratory specialist nurse.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- The practice provided responsive care for children and younger people, ensuring all children could be seen that day.
- The midwife saw patients in the practice on alternate Tuesday afternoons.
- The practice carried out eight-weekly mother and baby checks. A health visitor provided a monthly 'drop-in' clinic and held regular child development clinics every week in between the drop-in service.
- The practice provided family planning services including coil and implant fittings, which were available at the Bakewell Medical Centre. This could not be undertaken at Tideswell as low numbers meant there were insufficient cases for staff to retain their competencies, but the merger meant that this service was available for patients who could travel to the practice at Bakewell.
- The practice could offer appointments outside of school hours to accommodate children at a convenient time.

Working age people (including those recently retired and students)

- The practice offered pre-bookable GP appointments in extended hours on one evening a week. Early morning appointments were available with the practice nurse, for example, to take bloods.

Outstanding ☆

Are services responsive to people's needs?

- The practice participated in a local extended access scheme which was being launched in October 2018. This offered access until 8pm Monday to Friday, and for three hours a day on a Saturday and Sunday. This was open to all patients residing in the Derbyshire Dales and operated across four hub sites on a rotational basis.
- The practice offered telephone appointments when appropriate.
- Online services were available including appointment bookings, repeat prescription requests, and patients could request access to coded medical records. The electronic prescription service was not available at the time of the inspection, but the practice was hoping that this could be rectified. Online access uptake was very high with approximately 30% of patients signed up for online services, exceeding the local NHS target of 20%.
- A Saturday flu clinic was provided to help working age people access the service more easily.

People whose circumstances make them vulnerable:

- The practice was aware that the rural community, including farmers, often did not routinely access health support. They tried to address this with opportunistic screening and testing, and helped established a nursing service at Bakewell Agriculture Centre.
- The practice retained input at Taddington to try and engage with individuals who may not want to travel to the main surgery. Medicines were delivered to this location once a week also.
- Patients and their families were signposted to local services to help support them with alcohol or substance abuse.
- The Citizens Advice Bureau attended the practice each week to provide information and advice on financial, legal and other personal matters of concern.
- The practice had a range of easy read information for patients with a learning disability. This included information on cervical screening, invitation letters to health checks, and health action plans.
- The practice was a recognised 'safe haven' for patients with a learning disability. This was a partnership development instigated by Derbyshire County Council and the police. The scheme aimed to help people with learning disabilities to feel safe and confident in the community by having access to places which would support them if they needed help.

People experiencing poor mental health (including people with dementia):

- The practice provided patients with details on self-referral to local counselling services and other services to promote good mental health. A counsellor attended the practice each week.
- The practice worked with the local mental health crisis team, community psychiatric nurses, and social care professionals to meet the needs of their patients. Examples included arranging a meeting with the community psychiatric team to create a management plan for an individual who had been particularly unwell. On the day of our inspection, we saw the practice respond to a patient in distress to ensure they were safe and in receipt of urgent care and support.
- Care workers were encouraged to attend appointments with the patient's consent.
- Double appointments were available for patients with mental health problems so they did not feel rushed. Follow up appointments were booked during the consultation. Telephone consultations were also available should these be required.

Timely access to care and treatment

Patients were easily able to access care and treatment from the practice within a prompt timescale to meet their needs.

- Patients could get an appointment with a GP every day the practice was open.
- The practice offered online booking for appointments and the ordering of repeat prescription.
- Patients overwhelmingly reported that the appointment system was easy to use, and they were extremely pleased with the ease in obtaining an appointment.
- The practice used an automated appointment text reminder system to help reduce DNA (did not attend) appointments.
- Patients could access evening and weekend appointments in extended access hubs at GP surgeries across four local hub sites. These could be booked by Tideswell Surgery reception staff and were available for pre-bookable appointments with a GP. Patient comment cards also provided strong evidence of how patients appreciated access to such a responsive service.

Outcomes from the most recent GP patient survey, published in August 2018, showed that patient satisfaction

Are services responsive to people's needs?

in relation to access to the service was significantly above local and national averages. For example, 99% of respondents described their experience of making an appointment as good (CCG average 71%; national average 69%)

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted on complaints to improve the quality of care.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The partners were supported by a management team consisting of a partnership manager a project manager (both primarily based at Bakewell Medical Centre) and a patient services manager (based at Tideswell for day-to-day operational issues).
- GP partners and managers were knowledgeable about issues and priorities relating to the quality and future of services. Business meetings were held monthly.
- The partners and managers were visible and approachable. They worked closely with staff and others to ensure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including succession planning arrangements for the practice.
- Clinicians had identified lead areas of responsibility, and some GPs worked in wider roles outside the practice which added value to the continuous development of the practice.

Vision and strategy

The partnership had a clear vision to deliver high quality, sustainable care.

- The practice had merged with Bakewell Medical Centre in 2017 as part of a longer-term sustainability programme, prompted by the retirement of one of the partners. The integration had been handled successfully with no disruption to patient care or service continuity. The appointment of a project manager helped to oversee that the integration was managed effectively.
- The practice had a clear strategy in line with the NHS Five Year Forward View and local commissioning priorities.
- The practice had a written mission statement underpinned by a set of values. In a recent staff survey, the practice had asked staff about their understanding of these and as some staff had said they were unclear, managers intended to do some work to promote this.
- The practice planned its services to meet the needs of the practice population and was in line with health and social priorities across the region.

Culture

The practice had a culture of high-quality sustainable care.

- The practice focused on the needs of patients.
- Staff stated they felt respected, supported and valued. They were proud to work in the practice. There was low staff turnover.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were given protected time to support their professional development.
- There was an emphasis on the safety and well-being of all staff.
- The practice promoted equality and diversity and had a policy to support this.
- There were positive relationships between staff and individuals/teams who worked with the practice.

Governance arrangements

Responsibilities, roles and systems of accountability to support good governance and management were mostly evident.

- Structures, processes and systems to support good governance and management were established, understood and effective. However, some areas required strengthening to enable greater oversight, for example fridge monitoring, the sign-off of significant events, and the recording of GP training.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Good

Are services well-led?

- There was a timetable of regular practice meetings, including clinical meetings where topics including new and revised guidance, prescribing data, clinical incidents and complaints, and emerging risk could be discussed.
- A GP attended the local CCG-led clinical governance leads meeting, and provided feedback to the practice team on relevant issues.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice monitored, reviewed and benchmarked activity. This helped it to understand risks and gave a clear, accurate and current picture of performance and enabled corrective actions to be taken if required.
- Practice leaders had oversight of safety alerts, incidents, and complaints.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The practice used information to assess performance and to take corrective actions if these were indicated. The practice engaged with their CCG to discuss performance. We saw information provided by the CCG that showed no concerns with the practice's recent performance.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. A patient participation group was in place.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for continuous improvement and innovation.

- The practice was able to demonstrate how they reviewed service delivery and planned effectively for the future. For example, they had influenced national policy about the development of extended access hubs.
- The practice was involved in a local 'Train the Trainer' pilot with Derbyshire Healthcare NHS Foundation Trust to improve engagement and care coordination for patients experiencing poor mental health.
- The practice participated in a screening tool for atrial fibrillation (a common abnormal heart rhythm) using a smartphone application. This proved useful particularly in rural settings where patients were often reluctant to travel to a hospital for an electrocardiogram (ECG), a test that can be used to check the heart's rhythm and electrical activity.

Please refer to the Evidence Tables for further information.