Moss Valley Medical Practice

Quality Report

Gosber Road
Eckington
Sheffield
S21 4BZ
Tel: 01246 439101
Website: http://www.mossvalleymedicalpractice.co.uk/

Date of inspection visit: 29 April 2015
Date of publication: 19/11/2015

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?	Outstanding
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 carried out an announced comprehensive inspection at Moss Valley Medical Practice on 29 April 2015. Overall the practice is rated as Good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice:

- The use of a community pharmacist had improved outcomes for patients including, safer medicines management, reduced emergency admissions and greater cost effectiveness of medicines. For example

Summary of findings

data showed that Emergency admissions for patients aged 65-75 amongst the lowest in the CCG area at 230 admissions per 1000 patients compared to a CCG average of 250.

- The practice had proactively provided clinics in the community to avoid patients needing to be referred to secondary care. For example; GP's with special interest and additional training provided additional services, such as dermatology and musculoskeletal clinics to be provided from the practice enabling treatment to be provided more promptly. This service provision had resulted in the practice having the lowest rate of dermatology referrals to secondary care in the CCG area. The CCG rate of referral was 17 per 1,000 patients and practice rate 7 per 1,000 patients.
- Weekly care home ward rounds and medicines reviews by a prescribing pharmacist employed by the practice, as well as robust joint working between practice and community staff had reduced emergency admissions. A&E admissions were particularly low for patients aged 65 and over and 75 and over at 230 per 1,000 patients and 350 per 1,000 patients. The local CCG average was 250 and 400 per 1,000 patients respectively.

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

Importantly the provider should;

- Develop a system for recording what training has been completed and what is still required by staff.

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. Thorough analysis of each incident and event had been carried out by the practice and any learning was disseminated to all staff. Risk assessments were in place but these were not always detailed, particularly those for fire and health and safety.

There were enough suitably qualified and trained staff to meet patients' needs and keep them safe. Robust and effective systems were in place for the management of medicines. The practice had safeguarding procedures in place and staff had undertaken training to help protect children and vulnerable adults from the risk of harm.

Infection prevention and control systems were in place and staff had access to suitable and well maintained equipment.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

National data showed that the practice had lower than the Clinical Commissioning Group (CCG) average referral rates to secondary and other community care services for the majority of conditions and below national average rates of admission for all conditions.. For example trauma and orthopaedic and dermatology attendances. This was directly attributable to clinics run from the practice by GPs with special interests. This was a service provided for the whole community and the service provision had resulted in the practice having the lowest rate of dermatology referrals to secondary care in the Clinical Commissioning Group (CCG) area. The CCG rate of referral was 17 per 1,000 patients and practice rate 7 per 1,000 patients.

Clinical audits were used to improve outcomes for patients, such as the management of diabetes and regular audits were planned for the year ahead.

Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines.

The practice was using innovative and proactive methods to improve patient outcomes such as employing a community pharmacist. The use of the community pharmacist had resulted in positive patient outcomes which included a reduction in medicines error reporting and medicines optimisation for patients with chronic

Summary of findings

and long-term conditions through regular review. The practice reported the impact of the pharmacist was that patients were on the lowest, most effective dose of their medicines. For example a review of nine care home patients identified ten medicines that were no longer prescribed or appropriate for the patient. These were removed from the prescription. The same review identified and additional eight medicines that were switched to those that were, safer, more effective, easier to administer or take for the patient and more cost effective.

The practice pharmacist provided weekly medicines reviews for care homes and daily protected clinical learning time after surgery for their staff. Other local healthcare provider's professionals and providers including care home staff, district nurses and health visitors were invited to practice learning events and strong working relationships were in place to ensure sharing of best practice.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data from GP national patient survey published in 2015 showed that patients rated the practice higher than others for several aspects of care. For example 92% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care. This was above the local CCG and National averages of 86% and 81% respectively

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. All consultations and treatments were carried out in the privacy of a consulting room.

Information to help patients understand the services available was easy to understand. We observed a patient-centred culture, for example listening to and acting on patent feedback around appointments and access to services and support for families and carers following bereavement. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. For example, the use of a community pharmacist to improve medicines management and walk in appointments for young people with acute illnesses who were not registered to avoid them having to access secondary care services.

Summary of findings

It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is made up of patients of the practice who work with staff to improve the service and the quality of care. For example the use and positioning of the touch screen log in. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment and a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice had responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision to "provide excellent patient care and to develop to meet the challenges of the NHS practice"

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 the senior partner was the lead for safeguarding. We spoke with members of staff and they were all clear about their own roles and responsibilities.

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 although we noted some of these lacked detail and required updating. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and held regular patient information evenings. 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. The practice employed a care coordinator and community matron who assisted older and vulnerable patients after their hospital discharge and with accessing social care. Weekly ward round visits and weekly medicines reviews were carried out by the practice to three local care homes which staff at the care homes and practice told us had resulted in lower emergency admissions and improved communication with staff. Data showed that Emergency admissions for patients aged 65-75 amongst the lowest in the CCG area at 230 admissions per 1000 patients compared to a CCG average of 250. Staff at a local care home told us the medicines reviews undertaken by the community pharmacist employed at the practice had led to an almost total reduction in prescription of anti-psychotics which had led to a decrease in the number of falls by patients registered at the practice who lived in the care home.

Patients over the age of 75 years had a named GP to ensure continuity in care. Monthly end of life care meetings were held with non-practice staff.

The practice operated an on call rota system to allow flexible home visits to patients requiring this and to maintain continuity of care. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example the percentage of rheumatoid arthritis patients who had received an assessment of fracture risk was 90.9% compared to local and CCG averages of 86.1% and 82.1% respectively.

People with long term conditions

Good

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

A clinician held lead responsibility for each long-term condition which allowed them to develop personal expertise and provide supervision and learning to other staff. The practice pharmacist and nurses support the GPs in their work to provide care to patients in this group.

Longer appointments and home visits were available when needed. The practice had achieved 100% QOF points in 2014/15 and this was reflected in the robust disease management processes we saw. The practice had introduced an annual review for patients where all conditions could be managed within one visit split across nine months and effective recall systems were in place.

Summary of findings

. For those people 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 those 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 and exceeded local and national averages. For example infant Hib, Infant MEN C and the combined booster were all at 100% compared to a CCG average of 98.2% to 99.1%

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. The practice had a community focus in the way it provided care and treatment to the younger population group and acutely unwell young people could access an appointment even if they were not registered patients.

We saw good examples of joint working with midwives, health visitors and school nurses. Including GP's attending the local school to deliver health information sessions.

All GP partners had gained additional diplomas in family planning and were able to offer comprehensive sexual health advice to all patients. This had improved access to care and advice for patients which was evidenced by the practice achieving 100% of all Quality and Outcome Framework performance points for contraception, maternity services, and cervical screening, which exceeded local and national averages. For example rates for cervical screening were 79.2% which exceeded the local CCG national figures of 79% and 74%

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).

Summary of findings

The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Patients told us they had chosen to register with the practice due to the convenience of opening times and access to appointments.

The practice was proactive in offering online services such as electronic prescriptions and appointment booking, as well as a full range of health promotion and screening that reflects the needs for this age group. Flexible telephone call back appointments are offered to meet the needs of working patients.

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 looked after children, vulnerable adults and children and those with a learning disability. It had carried out annual health checks for people with a learning disability and all 43 patients had received a health review. It offered longer appointments for people with a learning disability or those who required them.

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 and excellent robust system were in place to identify and protect people who may be at risk of harm.

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. Non practice health care staff spoke positively about the practices involvement in safeguarding meetings.

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).

100% of people experiencing poor mental health had received an annual physical health check. The practice hosted an IAPT (Improving Access to Psychological Therapies) team which enabled access for patients.

The practice completed care plans for all 82 patients on their register with dementia. We saw that all 82 had received an annual review.

Summary of findings

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 had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had 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. 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

We received 28 patient comments cards from our Care Quality Commission (CQC) comments and the majority of comments were positive. All patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some patients gave examples of receiving good care as a result of this being effectively coordinated by the practice and other multi-disciplinary professionals.

Patients described the practice as clean and tidy and confirmed they could access same day appointments for both children and adults when needed. Patients said they felt the practice offered an excellent service and staff were caring, reassuring and helpful. Three patients made comments that were less positive and these were about the appointment system, waiting times and being able to see the GP of choice.

We looked at the national patient survey published in January 2015. The survey found that 90% of respondents stated that they were able to get an appointment last time they tried (above CCG average of 86%) and 93% said the last appointment they got was convenient which was the same as the CCG value (93%). However only 42% of respondents said they were able to make an appointment with their preferred GP, which was below the CCG average of 62%.

When asked if they would recommend the practice to someone new to the area, 85% of respondents said they would and 96% of respondents rated their overall experience of the practice as good. These were both above the CCG and National averages of (82% and 78%) and (89% and 85%) respectively.

Areas for improvement

Action the service SHOULD take to improve

- Develop a system for recording what training has been completed and what is still required by staff.

Outstanding practice

- The use of a community pharmacist had improved outcomes for patients including, safer medicines management, reduced emergency admissions and greater cost effectiveness of medicines. For example, data showed that Emergency admissions for patients aged 65-75 amongst the lowest in the CCG area at 230 admissions per 1000 patients compared to a CCG average of 250.
- The practice had proactively provided clinics in the community to avoid patients needing to be referred to secondary care. For example; GP's with special interest and additional training provided additional services, such as dermatology and musculoskeletal clinics to be provided from the practice enabling treatment to be provided more promptly. This service provision had resulted in the practice having the lowest rate of dermatology referrals to secondary care in the CCG area. The CCG rate of referral was 17 per 1,000 patients and practice rate 7 per 1,000 patients.
- Weekly care home ward rounds and medicines reviews by a prescribing pharmacist employed by the practice, as well as robust joint working between practice and community staff had reduced emergency admissions. A&E admissions were particularly low for patients aged 65 and over and 75 and over at 230 per 1,000 patients and 350 per 1,000 patients. The local CCG average was 250 and 400 per 1,000 patients respectively.

Moss Valley Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP, a second CQC inspector, a Practice Manager and a Practice Nurse.

Background to Moss Valley Medical Practice

Moss Valley Medical Practice is located in Eckington, near Sheffield and is part of the NHS North Derbyshire Clinical Commissioning Group (CCG).The practice is located in a purpose built health centre and serves a patient population of 8,295. Data shows the practice serves one of the least deprived areas of the country. People living in more deprived areas tend to have greater need for health services.

The staff team comprises five partner GPs, three female and two male along with one male and one female salaried GP. Three of the partners work full time with the remaining GP's working part time. The practice team includes a practice manager, four practice nurses, a pharmacist working four days per week, two Healthcare Assistants (HCAs) and reception and administration staff. The practice is also a training practice for medical students and GP's. At the time of our inspection there were three GP's in training at the practice.

The practice has a General Medical Services (GMS) contract with NHS England. This is a contract for the practice to deliver general medical services to the local community or communities and is a fund holder practice.

Moss Valley Medical Practice opening times are: Monday, Tuesday, Wednesday and Friday 8:00am to 6:30pm. The practice has extended hours on Thursday 7:00am to 7:30pm. Appointments were available at all times during opening hours.

The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen by Derbyshire Health United when the practice is closed through the out-of-hours service operated via the111 service.

Why we carried out this inspection

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

We carried out 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?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew, for example the CCG and local HealthWatch We carried out an announced visit on 29 April 2015. During our visit we spoke with a range of staff, GPs, practice nurses, a pharmacist, practice manager, reception staff and trainee GP's. We spoke with five patients who used the service. We observed how patients were communicated with. We reviewed 28 CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. Following our visit we spoke with staff at two care homes with patients registered at the practice.

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. These were discussed at monthly practice meetings and learning points were identified and shared with staff.

We reviewed safety records, incident reports and minutes of meetings where these had been discussed for the last 12 months. The records showed that thorough analysis of each incident and event had been carried out by the practice and any learning was disseminated to all staff. Each event had an action plan in place with named staffed allocated to addressing the issue. Evidence was available to show practice had managed incidents consistently over time and so could show evidence of a safe track record over the long term.

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 two years. Significant events were discussed at a number of meetings including the practice meeting and Multi-Disciplinary Team (MDT) meetings to ensure any action points and learning were shared with the most appropriate staff. Additionally a dedicated meeting was held monthly 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.

Staff used incident forms and we looked at a number of incidents. We found records were completed in a comprehensive and timely manner and action was taken as a result. For example, the practice provided all staff with additional training in diabetes care to ensure that the care provided reflected nationally recognised standards. 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 electronically to practice staff and stored in folders on computer desktops. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at multi-disciplinary meeting and shared with non-practice staff such as district nurses and health visitors which helped ensure all staff involved in a patients' care were aware of where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, and vulnerable adults. Not all administrative staff had received relevant role specific training on safeguarding. However, further training opportunities had been planned for these staff following our inspection.

We asked members of medical, nursing and administrative staff about their most recent training and they confirmed they had received training and knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly, record safeguarding concerns and knew how to contact the relevant agencies in and out of normal hours. Contact details were easily accessible.

The practice had appointed two GP partners as leads in safeguarding vulnerable adults and children. They had been trained to an appropriate level and could demonstrate they had the necessary knowledge to enable them to fulfil this role. All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

Systems were in place to identify and follow up children, young people and families living in disadvantaged circumstances, including looked after children. Robust systems were in place to identify and protect children at risk of harm. For example, the practice followed up children's attendances at A&E and those that had repeatedly missed immunisation appointments. GP's attended all child protection case conferences where possible. If they were unable to attend they sent in a report.

Good

Are services safe?

The district nurse, community midwife and health visitor we spoke with commented positively on the practice staff involvement and commitment to child and adult protection. Noting this was the only practice in the area that regularly attended safeguarding meetings.

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: patients with learning disabilities and those with caring responsibilities.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after by the local authority or subject to child protection plans were clearly flagged and reviewed. There was good liaison with partner agencies such as the health visitor, midwife and social services. For example, where concerns had been raised regarding a child's development. The concerns had been discussed with the health visitor and was scheduled to be discussed at the wider case conference.

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 and the majority of reception staff had been trained to be a chaperone. All staff had DBS checks in place and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a 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 and the healthcare assistant administered vaccines using directions appropriate to their role and qualifications which had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the healthcare assistant had received appropriate training to administer vaccines. The pharmacist was an independent prescriber and received regular supervision and support in his role as well as updates in the specific clinical areas of expertise for which he prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The pharmacist checked every prescription and initiated a medicines review where required to ensure patients received appropriate medicines.

All prescriptions were reviewed and signed by a GP and or pharmacist 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 use of an in house pharmacist meant the practice had very robust quality assurance process for medicines management. For example the pharmacist checked each prescription and discharge letter and compared medicines to ensure they were appropriate. Additionally the practice had lower than CGG and national average spending on medicines. As part of improvement work, we found the pharmacist had/was rewriting protocols around prescribing and medicines management to ensure staff had up to date procedures to follow.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. 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 new lead for infection control and who was due to undertake further training to enable them to provide advice on the practice infection control policy and carry out staff.

Good

Are services safe?

All staff received induction training about infection control specific to their role and this was also discussed in staff meetings. We were told staff received annual updates although we could not confirm this as there was no system for recording the training staff received centrally.

The infection control lead had carried out audits; the most recent had been completed in December 2014. As a result, new pedal bins, updated cleaning schedules and procedures were put in place.

An infection control policy and supporting procedures were available for staff to refer to and there was personal protective equipment including disposable gloves, aprons and coverings 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. There was also 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.

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 thermometer.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice's policies to manage and monitor risks to patients, staff and visitors to the practice were not sufficiently robust. For example, the policy for health and safety was a one page document and did not contain sufficient information to guide staff in line with Health and Safety Executive (HSE) requirements. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks assessed with mitigating actions recorded to reduce and manage the risk. For example, risks such as slips and trips, legionella (British gas service annually) and evacuation.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, a patient became unwell in the reception area and required emergency medical care

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 (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked once weekly.

Staff also had access to emergency kits which were accessible by key code. All staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Good

Are services safe?

The practice had a business continuity plan which had been updated in 2015. The plan detailed the actions to take in response to a range of emergencies that may impact on the daily operation of the practice. The plan covered a range of major incidents, emergencies and clinical issues such as mass vaccination, utility problems such as power supply and smart card problems.

We noted the practice had emergency and fire evacuation procedures in place for staff. Weekly fire tests were undertaken as well as an annual fire alarm test. An independent test of emergency lighting had been completed. A fire drill was carried out the week prior to our inspection.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated.

GPs and nurses used the electronic system to complete 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 such as sports medicines, dermatology, and long-term conditions and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with asked for and provided colleagues with advice and support to ensure the best outcomes for patients.

GPs had additional qualifications and specialist interest in a range of conditions including dermatology and musculoskeletal (MSK) and sports medicine. They had used this expertise to provide clinics at the practice to improve health outcomes for patients, from Moss Valley and four other local practices, in these areas and ran a dermatology clinic (procedures undertaken included incision biopsy, lumps and bumps) at the practice meant patients did not have to travel to a hospital to access services. Services at this clinic were also available to patients from other practices therefore catering for the wider community. This service provision had resulted in the practice having the lowest rate of dermatology referrals to secondary care in the Clinical Commissioning Group (CCG) area. The CCG rate of referral was 17 per 1,000 patients and practice rate 7 per 1,000 patients.

Similarly, patients from Moss Valley and four other local practices were able to access the MSK clinic for complex joint injections and treatments. This had improved outcomes for patients and reduced referral rates to hospital for this treatment. The practice referral rate was significantly below the CCG and national rates of 20 per 1,000 patients at 15 per 1,000 patients.

National data showed that the practice was below the CCG referral rates to secondary and other community care services for most conditions and below average for all conditions compared to the national figures. For example Trauma and orthopaedic attendances were 15 per 1,000 patients which was below CCG level of 21 per 1,000 patients.

Additionally the practice had the lowest referral rates to hospitals, emergency admissions and A&E attendances in the CCG area; an average of 7 per 1,000 patients compared to CCG rate of almost 10 per 1,000 patients.

The practice carried out proactive weekly visits to three care homes. Additionally the practice pharmacist carried out weekly reviews of medicines and prescriptions for all care homes.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need. All GPs we spoke with used national standards for the referral of suspected cancers to be seen within two weeks. 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.

The practice employed a full time community pharmacist who had been in post for three years. He had a range of responsibilities, including; scrutiny of all acute and repeat prescriptions, managing prescription queries regarding dosage, potential contra-indications and drug changes from clinical letters. He was also the lead for cost-effectiveness and medicines optimisation. This had helped the practice make a saving of £36,000 on its given budget in 2014.The use of the community pharmacist had resulted in positive patient outcomes which included a reduction in medicines error reporting and medicines optimisation for patients with chronic and long-term conditions through regular review. The practice reported the impact of the pharmacist was that patients were on the lowest, most effective dose of their medicines. For example a review of nine care home patients identified ten medicines that were no longer prescribed or appropriate for the patient. These were removed from the prescription. The same review identified and additional eight medicines that were switched to those that were either, safer, more effective, easier to administer or take for the patient and

more cost effective. We looked at eight similar reviews that had been carried out between May 2014 and March 2015, all of which showed similar improvements for patients and staff.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice showed us four clinical audits that had been completed recently and three of these were completed cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example an audit of prescribing of weight loss medicines resulted in an improvement in clinicians recording the patient's weight and BMI. These recording levels increased by 5% and 18% on reaudit. This resulted in improved effectiveness in respect of monitoring the impact of prescribing on patients' weight loss.

The practice had carried out a review of care for patients with a diagnosis of diabetes between April 2013 and April 2015. This included three completed audit cycles looking at, recording of blood pressure, measuring cholesterol levels and prescribing of medicines to manage diabetes. All three resulted in changes to procedures for the practice and improved outcomes for patients. For example, emergency admissions for patients with a diagnosis of diabetes were amongst the lowest in the CCG and the practice was the third highest performer in respect of completing all nine monitoring checks for patients with a diagnosis of diabetes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had achieved 100% QOF points in 2014/15 and this was reflected in the robust disease management processes we saw. It was not an outlier for any QOF (or other national) clinical targets. The practice had introduced an annual review for patients where all conditions could be managed within one visit split across nine months and effective recall systems were in place.

An outstanding feature we found was the proactive use of the pharmacist in medicines management and monitoring. The pharmacist had been employed at the practice for three years and was an independent prescriber and trained to undertake spirometry to the standards of Association for Respiratory Technology and Physiology. There was evidence of the positive impact of this appointment on patient care.

- The pharmacist reviewed patients (age appropriate / adults) with minor ailments and were able to start patients with a diagnosis of COPD, asthma and hypertension on treatment following a holistic assessment of their health needs. The pharmacist co-managed the patients' health needs with GP support. This arrangement meant patients were started on treatment early without have to wait for a GP appointment and this also freed up the GP's to concentrate on patients at most risk. This had a positive impact on patients with the practice having low referral rates for general medicine including respiratory conditions. The practice figure was 2.5 – 3 admissions per 1,000 patients. This was well below the CCG and National figures of 5.5 and 6 admissions per 1,000 patients.
- The pharmacist undertook weekly care home rounds to review patients' medicines and nutritional supplements of which they liaised with the dietician when needed. The pharmacist carried out weekly proactive reviews of medicines and prescriptions for all care homes. This had proved effective in improving outcomes for patients. For example, A&E admissions were particularly low for patient 65 and over and 75 and over at 230 per 1,000 patients and 350 per 1,000 patients. The local CCG average was 250 and 400 per 1,000 patients respectively. Staff at a local care home told us the reviews had led to an almost total reduction in prescription of anti-psychotics which had led to a decrease in the number of falls by patients registered at the practice who lived in the care home.
- The pharmacist had undertaken a GRASP-AF audit which had identified 68 patients at high risk of atrial fibrillation. GRASP-AF is a tool used in primary care to help GP's assess the risk of atrial fibrillation related stroke and effective management in patients. Twenty out of 68 patients had been reviewed and were receiving anti-coagulation therapy.

The practice worked towards the gold standards framework for end of life care in providing services for patients. The

practice maintained a register of patients receiving end of life care and worked closely with other health providers such as community nurses to meet the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records which showed that the majority of staff had undertaken recent resuscitation training and the GP's were all up to date with safeguarding adults and children training. We noted gaps in refresher training for nursing staff around safeguarding children and vulnerable adults. The practice were aware of this and provided evidence that additional training was booked. However the practice did not have a consolidated system to record staff completion of all training, for example infection control, health and safety or fire safety. Staff files we looked at did not contain evidence to confirm attendance at training.

Nurses had obtained relevant skills by attending individual training course identified as relevant. However we did not see evidence to confirm this training. For example, one nurse's recruitment file we looked at did not contain confirmation of attendance at training for diabetes, asthma or COPD; although we had been informed these were successfully completed.

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

We looked at ten staff files and saw evidence that all staff had received annual appraisal in the last year. Staff we spoke with told us they found the appraisal process helpful and felt supported by the practice. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with and following our inspection.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. All incoming mail was seen daily by GPs, whether out-of-hours information or otherwise, and actioned appropriately. GPs assigned read-codes to letters and saw, actioned and archived all test results. All staff we spoke with understood their roles and felt the system in place worked well.

All referrals were done via the choose and book system, with letters dictated by GPs. Routine letters were typed and sent within 48 hours, urgent within 24 hours and two week wait cancer referrals were sent the same day. We saw evidence that GPs discussed choice with patients when a referral decision was made and recorded agreement.

The practice held regular multidisciplinary team (MDT) meetings to discuss the needs of complex patients, such as those approaching the end of their life care or children subject to child protection plans. These meetings were attended by pharmacist, health visitor, school nurse and others. Decisions about care planning were documented in a shared care record. We saw notes of MDT meetings which confirmed discussions were held and demonstrated the provision of integrated care to patients which ensured they received a seamless service.

Information sharing

The practice used several electronic systems to enable patient data to be shared in a secure and timely manner with other providers or the out of hour's service. Care plans were shared with Derbyshire Health United the out-of-hours service provider.

The practice had signed up to the electronic Summary Care Record, although this was not used by Practice Nurse staff. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

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

Consent to care and treatment

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. There was a policy on consent available which considered patients' capacity to make decisions and covered obtaining consent from children and young people This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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. These care plans were reviewed a minimum of annually. There were 43 patients on the learning disability register and data supplied by the practice showed that 70% of them had their care plans reviewed in the previous year. 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 a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures or cryotherapy (removal of warts/ verruca's etc. using freezing liquid) 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.

Health promotion and prevention

The practice was very proactive in respect of health promotion; GPs told us they saw this as an integral part of disease management. For example patients had access to: a health trainer at the practice, and the practice displayed information on a themed board in reception.

The Patient Participation Group (PPG) led health information evenings as part of empowering patients on better self-care of their health conditions. A PPG is made up of patients of the practice who work with staff to improve the service and the quality of care. For example, the meeting held in September 2014 was attended by 30 patients and this was an interactive session on diabetes. The diabetic nurse, local diabetes UK volunteer and a GP also attended and shared information with patients. The PPG had also facilitated an evening on cardiovascular disease (CVD) in 2014. The practice exceeded local and national averages for all areas of diabetes and cardiovascular management as measured by QOF and Public Health England.

The practice was commissioned for enhanced services including smoking cessation, avoiding unplanned admissions and childhood vaccines and immunisations. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policies and procedures for these services were working well. This was evidenced by low A&E attendances and hospital admissions , success of smoking cessation programmes and high rates of childhood immunisation

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 77% of patients in this age group took up the offer of the health check. Staff told us patients were followed up by the GP if they had risk factors for disease identified at the health check and further investigations were scheduled.

The practice kept a register of all patients with a learning disability and all of the 43 patients were offered an annual physical health check. Practice records showed 30 patients (70%) had received a check up in the last 12 months. The practice had also identified the smoking status of 97.5% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients.

The practice's performance for cervical smear uptake was 82.4%, which was slightly better than others in the CCG area. Telephone reminders were used for patients who did not attend for cervical smears and. there was a named nurse responsible for following up patients who did not attend screening. Performance for national mammography (76.4%) and bowel cancer (61.8%) screening at the practice were all at or above national average (72.2% and 58.3% respectively), and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with

Outstanding ☆

Are services effective?

(for example, treatment is effective)

current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the GP national patient survey data which was published in January 2015. The survey was sent out to 269 patients and there were 115 returned responses. This was a 43% response rate. The survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 95% of respondents found the receptionists at this practice helpful which was above the Clinical Commissioning Group (CCG) average of 88%. The practice was also in line with or above average for its satisfaction scores on consultations with GPs and nurses. For example, 92% of practice respondents saying the GP was good at listening to them and 91% saying the GP gave them enough time (the local CCG averages were 91% and 92% respectively).

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 28 completed cards and the majority were positive 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. Three comments were less positive and the common themes related to appointments, waiting times and accessibility of GP of choice. We also 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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We saw that movable screens were available for use 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 practice switchboard was located away from the reception desk which helped keep patient information private. We observed patient services staff answering and making telephone calls. At all times staff were polite, helpful and respectful to callers and confirmed patient's identity before sharing information.

Care planning and involvement in decisions about care and treatment

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 also 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. This was confirmed by the results of the GP national patient survey, published in 2015 we saw. Patient feedback on the comment cards we received was also positive and aligned with these views

For example, data from the national patient survey showed 92% of practice respondents said the GP involved them in care decisions and 96% felt the GP was good at explaining treatment and results. Both these results were above the averages of the CCG 86% and 91% and national 81% and 86% and respectively.

Staff told us that telephone and one to one translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. Staff told us they had confidence in the translation service they used although the majority of patients with English as a second language did not have difficulty communicating or were accompanied by a relative.

We looked at a random selection of records for patients with learning disabilities, long term conditions and dementia and found that all had care plans in place. We saw that these had been reviewed annually and showed patients had been involved in the development and review of these plans.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment

Good

Are services caring?

cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

The national patient survey information we reviewed showed patients were positive about the emotional support provided by the nurse; For example, 93% of patients surveyed said that the last nurse they saw or spoke with was good at treating them with care and concern. The score for GPs was slightly below the CCG average at 82% - with the CCG average being 89%.

Notices in the patient waiting room told patients how to access a number of support groups and organisations, such as carers support, age concern and citizens advice.

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

Staff told us that if families experienced a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The practice was proactive in identifying and ensuring that carers received appropriate support in their role and their own health. Some of the practices work included the Patient Participation Group (PPG) organising a carer's information evening and being signed up to Derbyshire Carers Pledge. Care plans also identified a patient's main carer.

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 NHS England Area Team and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Various clinics and specialist services were offered and these included: ultra sound guided joint inspection, respiratory, sexual health services, sports medicines ante natal, adult vaccination and young people's health clinics. All GP partners had gained additional diplomas in family planning and were able to offer comprehensive sexual health advice to all patients. The additional availability of skilled trained staff had improved access to care and advice for patients. This was evidenced by the practice achieving 100% of all QOF performance points for contraception, maternity services, and cervical screening, which exceeded local and national averages.

The practice had the lowest rates in the CCG area for referrals to hospitals and emergency admissions. A&E attendances were an average of 7 per 1,000 patients compared to CCG average rate of almost 10 per 1,000 patients.

The practice carried out proactive weekly visits to three care homes, each home had a designated GP lead who was the main contact although other GP's attended when required. Care home staff we spoke with told us they found this very useful and felt it had improved outcomes for patients. For example, care home staff told us they had noted a reduction in the number falls and emergency referrals and hospital admissions. Care home staff held regular meetings with the practice which had improved communication and were also invited to multi-disciplinary meetings and learning events.

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). For example a touch screen appointment log in system had been put in place.

The PPG had designed posters highlighting the impact of the practice of missed appointments. The aim was to inform patients about the impact of failing to attend appointments and to discourage this.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, services for those with a learning disability or travellers, carers and people whose first language was not English. The practice had access to online and telephone translation services and one GP who spoke Mandarin Chinese and another British Sign Language. The practice had a population of about 99% English speaking patients though it could cater for other different languages through translation services.

The premises and services had been adapted to meet the needs of patient with disabilities. For example, there was a hearing loop system available for patients with a hearing impairment and level access for people with mobility needs. There were automatic doors to the building, which made easy access for wheelchairs users and patients with pushchairs.

The practice was situated on the ground and first floors of the building, with services for patients on the ground floor. There was lift access to the first floors. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities although we noted these did not include alarm cords.

Access to the service

Appointments were available Monday, Tuesday, Wednesday and Friday 8:00am to 6:30pm. The practice held extended hours appointments on Thursday 7:00am to 7:30pm. The practice's extended opening hours on Thursday was particularly useful to patients with work

Good

Are services responsive to people's needs?

(for example, to feedback?)

commitments. A patient we spoke with told us that they had chosen to register with this practice due the availability and accessibility of later appointments for working people and families.

The practice operated an on call rota system for GP's to allow flexible home visits to patients who required it and to maintain continuity of care.

Online access to records was enabled in October 2014 and auto attendant (a telephone management system) was implemented in February 2015. Patient survey data showed this had resulted in patients having greater access to their care records and improved telephone access to the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Longer appointments were also available for patients who needed them, including older people and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients who required them.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. This was confirmed by data from the GP national patient survey published in 2015 which showed 90% of respondents were able to get an appointment to see or speak to GP the last time they tried compared to the local (CCG) average of 86% and the national average of 85%. Additionally 78% of respondents found it easy to get through to the practice by phone compared to a local (CCG) average: 75% and a national average of 74%.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. The practice operated an 'extras' appointment system whereby patients who were acutely unwell could access same day appointments. Young people who attended the practice acutely unwell, could access an appointment even if they were not registered patients. This system was also used for people experiencing poor mental health and vulnerable patients including those who were homeless

As part of winter pressure planning , the practice had introduced an extra GP session a week and increase the healthcare assistants capacity to 12 hours a week between November 2014 and March 2015

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 via the practice leaflet and information displayed in the waiting area. 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 18 complaints received in the last 12 months and found they were handled in a timely way and in line with the practice complaints policy. Complaints showed evidence of thorough investigation involving several members of staff and appeared to have been resolved to the complainant's satisfaction.

No recurrent themes were identified; however, lessons learned from individual complaints had been acted on.

Staff we spoke with told us that any learning from complaints was discussed at team meetings and were necessary, changes to practice were implemented.

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, "Provide excellent patient care and to develop to meet the challenges of the NHS practice." Some of the objectives included to deliver high quality care to its registered population, continue to develop practice premises and maximise practice income whilst maintaining a desired level of work and life balance. We found details of the vision and practice values were part of the practice's 2014-16 business plan. The practice vision and values included putting patient's first, maintaining high professional standards, commitment to training and development, team working, collaborative working. These values were clearly displayed in the waiting areas and in the staff room. Staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

The leadership was also aware of its challenges which included succession planning, recruitment, patient access and capacity. The practice staff demonstrated a commitment to address these areas.

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 most staff had completed a cover sheet to confirm that they had read the policy and when. All policies and procedures we looked at had been reviewed annually and were up to date. However the health and safety policy was very brief consisting of a single page which lacked sufficient detail to manage risk.

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 the senior partner was the lead for safeguarding. We spoke with 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. 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 e.g. diabetes and implementing preventative measures. The results are published annually. The QOF data for this practice showed it was performing above national standards having achieved 100% in 2014/15. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. We looked at a report compiled by the Clinical Commissioning Group (CCG) which compared all practices in the locality against a number of areas including planned and elective hospital admissions, referrals to secondary care and A&E attendances. This record showed that Moss Valley was performing amongst the best for the majority of outcomes and particularly well for low rates of emergency admissions for older people.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. Although risks had been assessed and action plans were in place, they contained limited information which may limit their effectiveness.

The practice held fortnightly governance meetings as well as meeting daily following appointment clinics for protected feedback and update meetings. We looked at minutes from previous governance meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Team meetings were held regularly, at least monthly. 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, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies and team meeting minutes if required (shared drive and system one to communicate).

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

The practice gathered feedback from patients through face to face contact, telephone conversations, patient surveys, comment cards, NHS choices and Friends and Family test.

The practice had an active Patient Participation Group (PPG) set up in April 2001 which had steadily increased in size to about 43 members. The aim of the group is to provide an opportunity for discussion and feedback between patients, their GPs and the rest of the practice team. The PPG group has established a general medical library of 150 books and has organised several well-attended information evenings, dealing with topics of importance to the general public. The group meets every two months.

The PPG used the general practice assessment questionnaire (GPAQ) as basis for patient survey. 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.

We looked at the results of the 2013/14 annual patient survey which was based on 412 responses. The key improvements agreed a result of patient feedback included increasing the number of appointments - the practice introduced two day release slots alongside routine book ahead appointments and on the day appointments. Patients also felt improvements were required in ensuring continuity in care.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions). Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with told us they were aware of the policy and would feel comfortable raising a concern. However we noted the policy did not include reference to or contact details for Care Quality Commission (CQC) or the CCG to offer staff further options to escalate their concerns or access support.

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. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. For example, the practice nurses and pharmacist have a weekly programme of continuing professional development headed by one of the partners giving them the opportunity to reflect on current practice and review latest guidance.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, following a mix up with a pathology sample, new systems were introduced for staff to check the name and details recorded on specimens before they were sent for analysis.

The practice was actively involved in quality improvement including medicines optimisation and development of care pathways related to dermatology which were shared with the CCG. At the invitation of the practice North Derbyshire CCG undertook a supporting quality improvement visit in March 2015. This was a follow up to a visit carried out in February 2014. The visited showed that the practice was performing well compared to similar practices in the area and had made progress on targets set. For example, the practice had very low attendance rates to A&E. The report identified that patients felt the practice should be their first point of contact for care. The practice had held development sessions for staff based on the report and supported the PPG with health education events for patients.

The practice was a GP training practice for four medical students and a registrar. The practice's linked objective was to develop the training status of the practice and deliver high quality care to its registered population. GP registrars are doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. We spoke with a number of GP registrars who told us there was strong leadership within the practice, they felt well supported and secure in their role.