Elmwood Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as good overall. (At the previous inspection undertaken in October 2014, the practice also received a good overall rating)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Elmwood Medical Centre on 5 March 2018. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider 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:

- There was a clear leadership structure and staff told us they felt well-supported by the partners and practice manager. We observed the positive impact this had in establishing a well-integrated practice team with low staff turnover and high morale.
- GPs and practice staff worked effectively as a cohesive team and provided personalised and responsive care to their patients.
- There was an emphasis on a patient centred approach in all aspects of the practice's work. This was underpinned by the practice's values.
- Results from the 2017 national GP patient survey showed that the practice had performed either above or in line with local and national averages regarding patient experience. The results had increased in 19 of the 23 indicators since the last survey was undertaken in 2016.
- The national GP survey showed that 88% of patients who responded would recommend the surgery to someone new to the area compared with the clinical

Summary of findings

commissioning group (CCG) average of 81% and the national average of 77%. This was reinforced by the Care Quality Commission (CQC) comment cards completed by patients prior to our inspection, which reflected that patients were highly satisfied with the care they had received.

- The practice had a strategy and forward vision. They worked with their local CCG and practices to maximise improvements in primary care for local patients. For example, the practice were seeking a solution to NHS England's requirementto ensure that patients had enhanced access to GP services, including appointments during evenings via an 8-8 service, and the provision of appointments at the weekend and bank holidays.
- There was a focus on continuous learning and improvement at all levels of the organisation. Staff training records were up to date, and regular appraisals encouraged development at all levels.
- The practice had an established quality improvement programme. This included a regular audit programme which demonstrated improvements in outcomes for patients.
- We found that the procedure for checking medicines within the practice was not sufficiently robust and we discovered two items of medicines and consumables that had exceeded their expiry date.
- The practice was able to demonstrate compliance with health and safety legislation. However, we observed one piece of broken equipment which had not been labelled or removed from a clinical room.
- The practice encouraged and supported staff to report incidents, although we found that there were generally low levels of incident reporting in the practice. There was some scope to enhance investigations into incidents and to share learning earlier and more widely.

The areas where the provider **should** make improvements are:

- Strengthen procedures to check for out of date medicines and consumables.
- Review the process for investigating incidents and sharing learning from significant events with all team members.
- Review the procedure for labelling and removing any broken equipment from clinical areas.

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

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

Elmwood Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector and a GP specialist advisor.

Background to Elmwood Medical Centre

Elmwood Medical Centre (www.elmwoodsurgery.co.uk) is registered with the CQC as a GP partnership with four GP partners. The practice has a population of approximately 8400 registered patients. The age profile of registered patients is mostly in line with local averages, but with a higher percentage of older patients in comparison to national averages. The practice has 21% of their patients aged 65 and over in comparison to a CCG average of 23% and national average of 17%. The practice serves a population that is ranked in the fifth least deprived decile for deprivation.

Elmwood Medical Centre provides primary care medical services commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The practice is situated in the town of Buxton in the Derbyshire High Peak area. It operates from a converted detached former residential property which opened in January 1992, with an extension being added in 1993.

The practice team consists of the four GP partners (two males and two females). There are three nurse practitioners, two practice nurses, and one healthcare assistant. The clinical team is supported by a practice manager, an assistant practice manager, with a team of twelve reception, secretarial and administrative staff. The practice also employs an IT manager. One member of staff is directly employed by the practice as a cleaner.

The practicesupports medical student placements from Sheffield Universityin their training.

The practice opens from 8am until 6.30pm Monday to Friday, with extended opening hours on a Wednesday morning from 7am, and until 7.45pm on a Tuesday evening. Scheduled GP appointment times are available each morning and afternoon.

The surgery closes for one afternoon a month on ten months of the year. This is to facilitate staff training. When the practice is closed, patients are directed to the out of hours' provider via the 111 service.

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments, including those for Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). There was a process in place to monitor water systems to control any potential risk of Legionella. The practice had received a specialist fire risk assessment, although we were unable to find evidence of a completed action plan at our inspection on 5 March 2018. The practice provided this information following the inspection, and we saw that this was comprehensive and updated to indicate when actions had been completed, and highlighted progress with the remaining issues that were being finalised. Staff received safety information as part of their induction and ongoing training programme.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. All staff received up-to-date safeguarding training appropriate to their role. Staff we spoke with knew how to identify and report concerns.
- The practice team worked with other agencies to support and protect patients from abuse, neglect, and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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 who acted as chaperones were trained for the role and had received an enhanced DBS check.
- There was a system to manage infection prevention and control. These systems had been strengthened since our previous inspection in 2014. A nurse practitioner was the identified infection control lead and they had received additional training in support of the role. An annual infection control audit was undertaken and we saw an action plan had been developed following the most recent audit in November 2017. There was a cleaning schedule in place for all areas of the practice, and these were complimented by periodic spot checks. We saw evidence that medical equipment was cleaned in accordance with manufacturers' instructions. There were systems in place to support the safe management of healthcare waste. Staff received training on infection control.
- The practice mostly ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. We found one piece of equipment that we were informed was broken although this had not been labelled as such, and had not been removed from the clinical room.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Reception staff had access to protocols for dealing with patients who may be presenting with an emergency condition such as chest pain, stroke or sepsis. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Sepsis had been discussed by the team at a clinical meeting in 2016, and equipment was available to enable clinicians to assess patients with presumed sepsis.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Good

Are services safe?

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- We reviewed a sample of referral letters and these included all of the necessary information.
- The practice had systems to ensure that any urgent incoming patient documents and pathology results were actioned promptly.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment mostly minimised risks. Recommended emergency medicines were mostly available and where they were not a risk assessment had been undertaken to justify the rationale for this. There was a documented process for checking medicines but we found one out-of-date medicine in the refrigerator, and out-of-date defibrillator pads in the emergency equipment. Doctors' bags had been centralised into two visiting grab-bags, and we found that these were well-organised and contained in date medicines and consumables.
- Staff prescribed, administered and gave advice on medicines to patients in line with legal requirements and current national guidance. There was evidence of actions taken to support good antimicrobial stewardship. We observed that the practice was amongst the best within their CCG in terms of prescribing performance. For example, they were in the top four of 35 practices in the CCG for low percentages of broad-spectrum antibiotic prescribing.
- The practice had a robust and safe process to ensure any patients being prescribed high-risk medicines were being monitored closely. This was complimented by monthly patient computer searches undertaken by the practice team to review that necessary monitoring was up to date and adhered to guidance. Patients' health was therefore monitored to ensure medicines were being used safely and followed up on appropriately. For example, the practice had developed a Lithium monitoring protocol to ensure the effective oversight of patients being prescribed this medicine.
- The practice kept prescription stationery securely and monitored its use. Staff adhered to a repeat prescription protocol to ensure any repeats requested were only issued with correct authorisation. Uncollected prescriptions were regularly reviewed and patients were followed up when this was necessary to make sure they had access to their prescribed medicines.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on incidents and significant events.
- Staff understood their duty to raise concerns and report incidents. Leaders and managers supported them when they did so, although we found that the level of reporting was low with only four incidents being logged since January 2017 to the time of our inspection on 5 March 2018. We found there was some scope for more detailed analysis and application of learning from the events that we reviewed.
- There were systems for reviewing and investigating when things went wrong, and we saw that learning was applied. For example, a patient had requested their medicines without realising these had been changed by the hospital following a recent admission. The practice then introduced a system to write and inform patients of any medicines changes that they had received in the hospital discharge letter.
- Incidents that were reported were reviewed at the weekly partners meeting. Discussion took place with the staff members associated with the event, and any wider learning was disseminated to relevant staff. An annual review of incidents was discussed with the practice team to review any recurring themes. The practice was mostly able to demonstrate how they had learned and shared lessons and took action to improve safety in the practice. However, some staff said they didn't always receive feedback on events apart from at the annual review.
- There was a system for receiving and acting on patient and medicine safety alerts. We saw evidence that when medicines alerts were received, searches were undertaken to identify patients this might affect, and these were then followed up and reviewed accordingly. The visiting CCG pharmacist took a lead on this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all six population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Clinicians were able to describe examples of recent discussions held in relation to new or updated guidance, and we saw that this was used to inform the practice's audit programme. Templates on the practice computer system automatically linked into NICE guidance.

- Patients' 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:

- Approximately 10% of registered patients were aged 75 or over. The high proportion of older patients meant the practice dealt with individuals who presented with one or more diseases or disorders, in addition to a primary condition. The practice encouraged these patients to attend for regular reviews with care and support from the wider team.
- Fortnightly multi-disciplinary meetings reviewed the ongoing care and support for patients who were at risk of hospital admission or had complex health and care needs. The practice team worked effectively with community based staff as part of an integrated approach to care.
- The practice worked with a care co-ordinator to follow up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any new or additional needs.
- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs, including a review of medication.

People with long-term conditions:

- Just over one third of registered patients were recorded as having a long-term condition. There was a slightly higher prevalence of these conditions in comparison to local and national averages. The practice was aware of this and targeted these patients for support, although this presented challenges in terms of time and resources.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.
- The practice had appointed an IT manager who focused on the coordination of long-term conditions management as part of the Quality and Outcomes Framework (QOF). The outcomes achieved in QOF demonstrated that the practice was effectively meeting the needs of patients with a long-term condition.
- Staff who were responsible for reviews of patients with long term conditions had received specific training in support of this.

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 in line with the target percentage of 90% or above.
- The practice provided contraception services including emergency contraception.
- Monthly meetings were held with the health visitor (including the school nurse on occasions) to review any children where there were any known safeguarding concerns. This meeting was open for all practice clinicians to attend, and ensured that all GPs and nursing staff were well-briefed about safeguarding matters. There was also dedicated administrative support to organise these meetings and coordinate follow up including the coding and updating of patient records.
- The practice had procedures to follow up on children if they did not attend planned appointments, for example the six-week baby check.

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

- The practice's uptake for cervical screening was 84%, which was in line with the local average of 84% and national average of 81%. This was achieved with low

Good

Are services effective?

(for example, treatment is effective)

exception reporting rates of 2% (approximately 1.5% below local and 5% below national rates). This outcome contributed to the 80% coverage target for the national screening programme.

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time. The practice attended the 'fresher's' fair' for Derby University students residing in Buxton to promote healthy lifestyles and supply information about the practice.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74.

People whose circumstances make them vulnerable:

- The practice had identified a nurse practitioner as a domestic violence champion.
- Patients who were newly diagnosed with cancer were identified and included for discussion at the multi-disciplinary meetings to ensure their needs were accommodated and kept under review throughout their ongoing care.
- End of life care was delivered in a coordinated way with extensive collaboration from the fortnightly multi-disciplinary team meetings. The care provided took into account individual needs such as the patients preferred place of care.
- The practice conducted a quarterly 'after death analysis' of patients with the primary healthcare team to consider any learning that may arise. We saw evidence that in the majority of cases where an expected death had occurred at a patient's home, the patient had been identified on the practice register with an accompanying care plan and issued with anticipatory medicines (medicines used for end-of-life symptom control being made available so that these can be given if required without unnecessary delay).
- The practice held a register of patients with a learning disability. The practice had completed annual health reviews for 67% of their 55 patients on this register during 2017-18 at the time of our inspection. This looked on target for achieving a similar outcome to the previous year in which 80% of learning disability annual health checks were completed.

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

- Two dementia support workers had provided a service to all three GP practice in Buxton for approximately the last two years. Their role was to help early diagnosis, aid screening and support existing diagnosed dementia patients and their carers in signposting them to support services. These workers would see patients at the practice or in their own homes.
- The practice maintained registers of patients with dementia (100 patients), and mental health (84 patients) and offered an annual check to review their needs.
- 71% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was lower than the local average of 82% and national average of 84%. However, exception reporting rates were approximately 3% lower than local and national averages.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was comparable to the local and national averages. Exception reporting rates were higher at 23% (7% above the CCG average, and 11% above the national average).
- The practice considered the physical health needs of patients with poor mental health and those living with dementia. For example, 94% of patients experiencing poor mental health had received discussion and advice about alcohol consumption in the last 12 months (CCG 94%; national 91%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

The most recent published Quality Outcome Framework (QOF) results for 2016-17 were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 99% and national average of 96%. QOF is a system intended to improve the quality of general practice and reward good practice. The overall exception reporting rate was 12.7% compared with a national average of 10%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). Practice

Good

Are services effective?

(for example, treatment is effective)

supplied data showed that the practice was set to achieve highly again for 2017-18 with the position on the day of our inspection showing at 95% with three weeks remaining before the final calculation.

The practice had made attempts to reduce exception reporting by contacting patients via a mixture of letters and texts, and we saw that patients were only excepted following three attempts to recall them. We noted that exception reporting rates for indicators relating to asthma were higher than local and national averages. However, the practice told us that they were tackling this by each nurse being assigned 20 patients to ring them directly and explain the importance of attending for a review of their condition.

The practice focused on providing regular reviews on all patients with a long-term condition, and not just those included within QOF. For example, patients prescribed statins (medicines to lower the level of cholesterol in the blood), and those patients with higher blood sugar levels but not at the threshold to be diagnosed with diabetes. All pre-diabetes patients were invited to attend an annual review of their condition.

The practice employed a part-time IT manager. As well as providing support to the team for any technological issues, the manager helped coordinate work to support the achievement of QOF targets and the recall of other patient groups. The IT manager worked with colleagues in the area to share template developments and knowledge, for example, we saw that the manager had developed a template for reporting deaths to the Coroner's Office which was then shared with other local GP practices. This manager had been invited to participate in the procurement of IT services for all Derbyshire CCGs in the previous year, as a GP practice representative.

The practice was actively involved in quality improvement activity, and was able to provide a timetable of their programme since 2016. Audits were selected in response to learning points from educational events, NICE guidance, QOF indicators where there was an indication that the practice was an outlier, and safety alerts. The practice provided us with examples of completed clinical audits which included a full cycle audit on reviewing antibiotic prescribing and the documentation of safety netting for cases of tonsillitis. The first cycle demonstrated that 63% of patient records included the appropriate recording of safety netting advice. The findings were fed back to colleagues at a clinical meeting and after the second cycle audit compliance had improved to 82%. Another audit had been undertaken of patients with a splenectomy or with a condition with reduced splenic function. These patient shad a higher risk of developing certain infections and required preventative vaccination. Patients were identified and invited to attend to receive a vaccination, and this resulted in an increased vaccination rate in this group from 4% to 59%.

A fortnightly referrals and prescribing meeting was held to review activity across the practice and provide assurance and safety netting of the nurse practitioners' work.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, 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. Up to date records of skills, qualifications and training were maintained and monitored. Individuals were encouraged and given opportunities to develop, and staff told us that the partners had funded courses for them that were relevant to their roles. For example, a nurse practitioner informed us that they were due to attend a leadership course that had been funded by the practice.
- Monthly meetings for GPs and nurses included updates on clinical issues. For example, we saw that recent topics included NICE guidance; a discussion on an article published in the British Medical Journal; and an update on contraception. External speakers were often invited to lead a presentation at this meeting, and clinicians documented their own learning on a personal reflection template.
- The practice provided staff with ongoing support. This included an induction process, regular meetings, appraisals, one to one support as appropriate, and support for revalidation. One GP was assigned to support and mentor the nurses.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Good

Are services effective?

(for example, treatment is effective)

- GP locums were rarely used apart from in circumstances such as winter pressures. Locums were sourced through established agencies or were known by the practice. They received information to support their work at the practice.
- A pharmacist from the CCG medicines management team worked across the three GP practices in Buxton. The pharmacist attended the practice on most days to offer support and advice on medicines management issues. Their input also provided an opportunity to share learning points and best practice in relation to medicines from outside of the practice.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Information was shared appropriately with out of hours' and other relevant providers to ensure a smooth transition across services for patients.
- The practice ensured that end of life care was delivered in a coordinated way which took into account 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 health. For example, there was access to smoking cessation and weight management advice from the Live Life Better Derbyshire Service. This service was also used to promote healthy lifestyles with patients presenting with signs of pre-diabetes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

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. Care home staff told us that GPs assisted in best interest assessments for their residents when this was appropriate.
- The practice monitored the process for seeking consent appropriately. For example, written consent forms were scanned into patient records when minor surgery was undertaken.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Patients told us that staff treated them with kindness, respect and compassion.

- The practice gave patients timely support and information. Staff understood patients' personal, cultural and social needs.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.
- The practice would refer appropriate patients to a local foodbank. Staff had also donated items to the foodbank at Christmas.
- Staff took part in fund raising activities, for example a recent coffee morning and raffle raised over £300 for a local hospice.
- The majority of the 36 Care Quality Commission patient comment cards we received, were positive about the service experienced. Patients said that staff were caring, supportive, and often exceeded their expectations. For example, one patient told us how their relative had been treated as a temporary resident, and was seen on the same day to provide the care that was required. Another patient wrote that a GP responded promptly to provide care to a sick child at home, and then arranged for their medicines to be delivered directly to their home. Five cards included a negative comment, two of which related to interactions with members of the practice team. However, one of these cards also included a positive comment about the practice in more general terms.
- The results of the NHS Friends and Family Test were consistently positive and we reviewed the returns from 1 April 2017 up to the day of our inspection on 5 March 2018. The responses showed that 31 of 34 respondents would be 'extremely likely' to recommend the service with the other three said that they were 'likely'. The national GP survey results from July 2017 indicated that 88% of respondents would recommend this surgery to someone new in the area, compared to the CCG average of 81% and national average of 77%.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 263 surveys were sent out and 127 were returned. This represented about 1.5% of the practice population. The practice was in alignment with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 90% of patients who responded said the GP gave them enough time; CCG - 88%; national average - 86%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 94% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 89%; national average - 86%.
- 94% of patients who responded said the nurse was good at listening to them; (CCG) - 94%; national average - 91%.
- 90% of patients who responded said the nurse gave them enough time; CCG – 94%; national average - 92%.
- 96% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 92% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 94%; national average - 91%.
- 88% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. A sign language interpreter had been arranged to support a deaf patient as part of their treatment session.

Good

Are services caring?

- Staff communicated with patients in a way that they could understand, for example, communication aids (such as a hearing loop) and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers, and the list was reviewed on a regular basis to ensure it was kept updated. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 111 patients as carers (1.3% of the practice list).

- A member of the practice team had just been nominated to become the practice's carers' champion to help ensure that the various services supporting carers were coordinated and effective.
- Staff told us that if families or carers had experienced bereavement, the practice sent a card to offer their condolences. If any individuals required support, this could be followed by a patient consultation and/or by giving them advice on how to find a bereavement support service.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 94% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 89% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 85%; national average - 82%.
- 93% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 93%; national average - 90%.
- 87% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- The practice complied with the Data Protection Act 1998, and all staff were up to date with training in information governance.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good 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. For example extended opening hours were available; online services such as repeat prescription requests were provided; and advanced appointment bookings could be made.
- The facilities and premises were appropriate for the services delivered. All patient services were delivered from the ground floor. There was good access for wheelchair users. Although the reception desk was at a high level, there was an area adjacent to reception which could be opened to talk with wheelchair users.
- The practice did not provide an on-site phlebotomy service as this was commissioned from three venues across Buxton. However, patients were able to book their phlebotomy appointments through the reception. In some cases, clinical staff would take patient bloods if these were required urgently, and we were informed that a GP took bloods for infants and children to avoid travelling to the hospital which was situated some distance away in Stockport.
- The practice provided minor surgical procedures for their patients at the local hospital.
- The practice had access to a 'consultant connect' scheme which gave a direct phone line to consultant at the nearest acute hospital and this service was available for haematology, gastroenterology, paediatrics and gynaecology. Access to timely expert advice helped to avoid unnecessary referrals or admissions to hospital.
- The High Peak area attracted many visitors. The practice worked with other local practices on a monthly rota to provide any urgent and necessary treatment required and saw these patients as temporary residents.
- The Citizens Advice Bureau provided a weekly session at the practice.
- An automated arrival system enabled self-check-in for patients, and free Wi-Fi was available.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Appointment reminders were sent to older and vulnerable patients, and these patients would be called if they did not attend for either a practice or hospital appointment.
- The practice provided care for residents at three (increasing to four in the near future) local care homes as part of an enhanced service. Fortnightly 'ward round' visits were made to each home by a named nurse practitioner and any urgent requests were responded to on the day by a GP. All of the patients had a personalised care plan, and where appropriate had a Do Not Resuscitate (DNR) order in place, and access to anticipatory medicines (medicines used for end of life symptom control if the patient is in the last days of life). The approach to effective care planning helped avoid crisis situations and reduce the number of urgent GP call outs, or unnecessary hospital admissions. The practice had appointed a new practice nurse to allow more capacity for the nurse practitioner to fulfil this role effectively. We spoke to managers at two of these care homes who informed us that their residents mostly received a good service from the practice. We were informed that there had been an occasion in which a patient had not received their end-of-life medicines following a visit by the nurse practitioner. However the home had discussed this with the practice and was assured that learning had taken place to prevent any future occurrences.
- The practice provided primary care support to an eight-bedded 'step-down' rehabilitation ward ata local hospital in Buxton. This was provided in partnership with the other two local GP practices, and involved two visits every week to review the patients.

People with long-term conditions:

- When patients were seen as part of their annual review and had one more than one presenting condition, they would be offered one recall appointment, rather than having to attend the practice more than once.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice held regular meetings and worked with community based teams to discuss and manage the needs of patients with complex medical issues.
- A diabetes nurse specialist attended the practice each month to review patients with more complex needs, and also provided insulin initiation on site for appropriate patients with diabetes. This nurse worked closely with the practice nurse.
- The practice worked closely with other specialist nurses, for example, the community heart failure nurses and respiratory nurses, to provide expert advice for those patients that required it.

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.
- All children were offered a same day appointment when necessary.
- Six-week old child health check clinics were held within the practice.
- The practice had an active social media profile.

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

- The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, online access to appointments and the ordering of repeat prescriptions, and extended opening hours appointments were available.
- Good access was aided by an 'on call' GP system.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours, or opted for this type of consultation as a preference.
- The practice offered a range of services which included travel vaccinations, contraceptive services, 24 hour blood pressure monitoring, spirometry (a test used to help diagnose and monitor certain lung conditions), and electrocardiogram (an ECG is a simple test that can be used to check a patient's heart's rhythm and electrical activity).
- A machine was provided for patients to check their own blood pressure and record the results. This helped to identify patients who may require follow up from a clinician.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Easy-read letters were available to help patients understand certain procedures. This included information leaflets for people with learning disabilities to enhance their understanding of cervical screening appointments.
- The practice provided care to residents in a local home for patients with a learning disability. A named nurse practitioner visited the home every fortnight, and the practice responded to any urgent issues as required.
- The practice welcomed people living in vulnerable circumstances, such as refugees and homeless people to register with the practice. The practice was able to describe how they had successfully engaged with a family of refugees to provide them with the care and support they needed. A practice nurse had attended an awareness session organised by the local authority to gain a better understanding of refugees' needs. The family were provided with double appointments to accommodate interpreting needs.

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

- The practice ensured that they followed up patients who did not attend psychiatry appointments
- Patients with complex mental health problems had care plans designed to accommodate their individual needs.
- The practice used their website, and information supplied in the practice, to highlight the availability of Improving Access to Psychological Therapies (IAPT) to facilitate easy access and self-referral to counselling for patients suffering with mental health issues.
- The practice provided mental capacity assessments when indicated, and referred patients to the Independent Mental Capacity Advocate Service

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- On the day of our inspection, we observed that patients could access an appointment on the day. Bookable appointments were available the next day with a nurse practitioner, and in less than a week with a GP.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was kept under constant review to enable the ongoing provision of good access for patients. There was flexibility inbuilt within the system to adapt to demand, for example by providing more capacity on Mondays and Tuesday, when demand was mostly at the highest.
- The availability of an 'on call' GP at each session assisted with triaging patients to ensure those with an urgent need were seen on the same day, and the GP also coordinated home visits. A template was used to prioritise visits and the availability of an on call doctor meant that visits could sometimes be undertaken earlier in the day, and this reduced pressures on the ambulance service following morning surgery.
- Nurse practitioners were utilised to see some patients as a first-line contact, with the patient's consent. These appointments were for 15 minutes, rather than the standard 10 minute GP appointment.
- Reception staff had access to a comprehensive summary of signposting information. This enabled reception staff to direct callers to the most appropriate service to meet their needs, and help to free up capacity at the surgery. The recorded practice telephone message advised patients that receptionists would ask about the nature of their condition in order to signpost them to the most appropriate service or obtain an appointment with an appropriate clinician. Members of the reception team had attended a course on signposting, where their approach was highlighted as good practice, and resulted in requests for sharing this with other participants and local practices.
- Advanced bookings could be made up to six weeks ahead.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above or comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 263 surveys were sent out and 127 were returned. This represented 1.5% of the practice population.

- 77% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 80% of patients who responded said they could get through easily to the practice by phone; CCG – 72%; national average - 71%.
- 87% of patients who responded said that the last time they wanted to speak or see a GP or nurse; they were able to get an appointment; CCG - 86%; national average - 84%.
- 91% of patients who responded said their last appointment was convenient; CCG - 84%; national average - 81%.
- 77% of patients who responded described their experience of making an appointment as good; CCG - 73%; national average - 73%.
- 68% of patients who responded said they usually got to see or speak to their preferred GP; CCG - 57%; national average - 56%.

The majority of the 36 Care Quality Commission patient comment cards we received were positive about the service experienced. Five cards included a negative comment, three of which related to access to appointments, although these comments were balanced with positive comments about the practice in all three cases.

On the day of our inspection, we saw that a routine GP appointment could be booked within one week, and advanced bookings to see a GP could be made up to two months ahead.

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 and it was easy to do. Staff treated patients who made complaints compassionately.
- The practice's complaint policy and procedure was in line with recognised guidance. Six complaints were received in the last year which we reviewed and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It

Good

Are services responsive to people's needs?

(for example, to feedback?)

acted as a result to improve the quality of care. For example, changes were made to the induction for new reception staff following a complaint which highlighted the importance of alerting GPs that a sick child was waiting to be seen.

Are services well-led?

Good

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

Our findings

We rated the practice, and all of the population groups, as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy. Clinical leadership was directed by GPs undertaking specific lead responsibilities such as prescribing, QOF and safeguarding.
- GPs and managers were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Regular partners' meetings were held to review priorities.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had encountered a difficult period since 2015 when two senior partners retired from the practice, along with the departure of the practice manager. The ability to recruit GPs nationally was a challenge, and the practice took the decision to replace some GP hours with nurse practitioner posts. A new practice manager was also appointed, who brought with them considerable experience of partnership working and financial management, adding a new dimension to the traditional practice management role. The partners had successfully integrated the changed structure, and we saw how the new arrangements had become embedded and were driving improvements.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision supported by a set of values. These focused on patient care and ongoing development.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The practice strategy was in line with health and social priorities across the region. This was in alignment with the NHS Five Year Plan. For example, the practice was working in collaboration with local practices to introduce an 8am-8pm weekday service, with hours also provided over the weekend and during bank holidays from October 2018.
- The practice planned its services to meet the needs of the practice population as demonstrated by their involvement in planning a potential 'health village' development for Buxton. Whilst this was still at an early stage, the practice was committed to work with the other two local GP practices, and acute and community health services in creating a facility that would meet the future needs of their patients and offer sustainability.

Culture

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

- The practice promoted a culture of innovation and change. GP partners and managers encouraged staff to contribute ideas to improve the service and a staff suggestion scheme was in operation. This encouraged proposals on how to make work better and staff received recognition when an idea was implemented, with the presentation a gift voucher. For example, a member of staff had developed a template to record patient deaths and this was disseminated to staff within the practice, and was also made available to other appropriate external professional staff. This ensured that staff were updated at the earliest opportunity to ensure they did not try to contact the person or their family following a death.
- 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. We saw evidence to confirm this when reviewing incident reports.
- Staff stated they felt respected, valued and enjoyed their work at the practice. Members of the practice team felt they were treated equally. The low turnover of staff supported these views.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so, and had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. All staff had received an annual

Are services well-led?

Good

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

appraisal, and new starters were reviewed after the first six months. Staff were supported to meet the requirements of professional revalidation where necessary.
- There were positive relationships between staff and teams. An annual team building event took place for the staff in June on one of the afternoon practice closures. Most recently this had been a bowling event, and the previous year it had been a team walk.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There was a schedule of regular in-house meetings including clinical meetings.
- GP partners and the practice manager worked with the clinical commissioning group (CCG) to help influence and drive improvement in the delivery of patient care within the locality. The practice manager attended local practice manager forums. There were well established links with other GP practices in Buxton who offered mutual support and shared good practice.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. This had been implemented during the recent computer virus affecting practice IT systems, and the adverse weather of the 'Beast from the East' which had caused major disruption to the Buxton area a few days before our inspection.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve 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 full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- Staff meetings were held on most months. These were held for non-clinical staff and clinical staff would join if they were not participating in a CCG led training event as these were held three times a year at the same time. Staff told us that since the practice manager's appointment in 2017, stronger communication channels had been instigated with team members.
- We were provided with an example where the partners had acted on concerns raised by staff. A new part-time receptionist was due to start work at the practice and this additional capacity had been agreed by the partners in response to staff feedback regarding workload.
- There was an active patient participation group in place. The PPG had quarterly meetings with practice

Are services well-led?

Good

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

representatives, and usually a GP would try to attend the meetings. We spoke with the chair of the PPG who told us that the practice was generally receptive to their suggestions and would try and find solutions to any issues they raised. For example, there had been discussions regarding access to appointments and patient feedback had inmproved further to some changes which were introduced.

- The practice analysed patient survey data and other patient feedback to consider any areas that could be improved. For example, a new telephone system had been purchased which improved patient experience, such as by letting callers know their queue position.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- A practice improvement plan had been developed based on a number of sources. This included the outcomes of patient surveys, staff feedback, infection control audits, and the findings of the CQC inspection. This provided a way of monitoring progress in addressing identified issues, and ensured the practice worked towards achieving their objectives in a timely fashion.
- The practice had developed a bid as part of a consortium to provide GP services between 8am-8pm Monday-Friday. The consortium was a collaborative approach between seven of the eight GP practices within the High Peak area. The proposed service would also be available for some hours at the weekend and bank holidays, and the plan was for the practices to contract this element form another experienced provider. Their model had initially been rejected by commissioners but the practice persisted with their proposal as the preferred 'single-hub' was not what work for their own patients due to the unique local geography. With support from the PPG and the local MP, the bid was subsequently approved and was due to come into operation in October 2018.
- The practice were actively involved in planning a potential 'health village' development for Buxton. The practice was committed to work with the other two local GP practices, acute, and community health services, in creating a facility that would offer opportunities to provide sustainable and integrated health care for their patients.
- The practice informed us that they encouraged a culture of innovation and change. We saw examples of this during the inspection. For example, the system for dealing with incoming correspondence had been amended so that the medical secretaries managed the majority of incoming letters and emails received each day. These were scanned directly onto the patient record if no action was indicated for a clinician, and scanned and forwarded onto the GP if there were any concerns or actions required. The necessary coding was then added onto the computer system. The system was safety-netted and audits were undertaken approximately every two months to check that the letters not being sent onto clinicians were being appropriately selected. The practice told us they believed this had resulted in GPs only receiving around 50% of the volume of letters in comparison to prior the implementation of this process.