Sett Valley Medical Centre

Quality Report

Hyde Bank Road, High Peak, Derbyshire SK22 4BP
Tel: 01663 743483
Website: www.settvalley.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sett Valley Medical Centre on 21 July 2016. Overall the practice is rated as outstanding.

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

- There was an effective system in place for the reporting and recording of significant events. Learning was applied from events to enhance the delivery of safe care to patients.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. An ongoing programme of clinical audit reviewed patient care and ensured actions were implemented to improve services as a result.
- The practice planned and co-ordinated patient care with the wider multi-disciplinary team to deliver effective and responsive care to keep vulnerable patients safe.
- The practice was committed to staff training and development and the practice team had the skills, knowledge and experience to deliver high quality care and treatment. The practice had an effective appraisal system in place.
- There was a good staff skill mix in place which included three nurse practitioner roles. The practice also contracted a pharmacist and a community matron to provide weekly sessional input at the practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. The practice analysed and acted on feedback received from patients.
- Patients provided generally positive views on their experience in making an appointment to see a GP or nurse.
- Longer appointments were available for those patients with more complex needs. An advanced nurse practitioner triaged calls and ensured that any patient requiring an urgent appointment was seen on the same day.
- The practice had good facilities and was well-equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure in place and the practice had a governance framework which supported the delivery of good quality care. Regular practice meetings occurred, and staff said that GPs and managers were approachable and always had time to talk with them.
- The practice had a clear vision for the future and included the practice team in reviewing and planning service delivery. The aspirations of the partners were in line with the CCG strategy of delivering high quality care closer to the patient's home.
- Information about how to complain was available upon request and was easy to understand. Improvements were made to the quality of care as a result of any complaints received.

We saw the following areas of outstanding practice:

- The practice had worked in collaboration with the UK Sepsis Trust over the last 18 months to promote the awareness and treatment of sepsis in primary care. This recognised that the early identification of symptoms and the use of effective safety netting was paramount within the primary care setting. This had led to the publication of an article written by the advanced nurse practitioner in the British Journal of General Practice in March 2016. A second project was underway to assess GP perception and knowledge of sepsis prior to the publication of NICE guidance on sepsis in July 2016. The ANP and GPs delivered training on sepsis to other primary care colleagues within their area, and aspired to influence a national sepsis promotional campaign.
- The practice was located in a semi-rural location and had configured its services to be responsive to the needs of their own patients and the wider patient community. For example, the practice provided a vasectomy service which enabled patients from other practices to receive this service, and to improve patient choice and access to local treatment.

The areas where the provider should make improvement are:

- Develop cleaning schedules to determine the extent and frequency of cleaning for each room, and review how this will be monitored.

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

- Staff reported all significant events, and learning was applied from incidents to improve safety in the practice. The practice demonstrated a commitment to safety through additional training and identifying a designated lead GP for incident reporting.
- The practice had robust systems in place to ensure they safeguarded vulnerable children and adults from abuse.
- The practice adhered to written recruitment procedures to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- Risks to patients and the public had been identified with systems in place to control these. For example, the practice had a designated infection control lead who undertook regular audits, and worked with the hospital microbiologist and local infection prevention and control teams for advice when required.
- The practice had undertaken significant work on the sepsis pathway to keep deteriorating patients safe within a primary care environment.
- There were effective systems in place to manage medicines and prescriptions kept on site appropriately. Patients on high risk medicines were monitored on a regular basis, and there were processes to follow up any patients who had not collected prescriptions within six weeks. Actions were taken to review any medicines alerts received by the practice, to ensure patients were kept safe.
- The practice had robust and highly effective systems in place to deal with medical emergencies, and we were provide with examples of this.
- The practice ensured staffing levels were sufficient at all times to effectively meet their patients' needs.
- The practice had developed contingency planning arrangements, supported by a comprehensive and up to date written plan which was regularly updated.

Are services effective?

Good

- The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

Summary of findings

- The practice had achieved an overall figure of 94.9% for the Quality and Outcomes Framework 2014-15. This was marginally below the CCG average of 98.1%, and consistent with the national average of 94.7%.
- The practice had developed comprehensive support for their patients with diabetes. This included the identification and support of patients with signs of pre-diabetes, and establishing a weekly multi-disciplinary meeting to review patients with diabetes.
- The practice had undertaken a project to standardise the way that suspected urinary tract infections were treated based upon national guidelines. The outcome was a decrease in the number of inappropriate samples being sent for urinalysis by one third and identified the practice as having one of the highest proportions of appropriate rationale for requests.
- A regular programme of clinical audit demonstrated quality improvement, and we saw examples of how audit was being used to enhance safe patient care and treatment.
- The practice had a good skill mix including advanced nurse practitioner roles. The practice employed their own care co-ordinator, and contracted a community matron and a pharmacist to provide care to their patients.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. New employees received inductions, and all members of the practice team had received an appraisal each year, which included a review of their training needs.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs, in order to deliver care effectively. This was supported by weekly meetings attended by a range of health and care professional staff.

Are services caring?

Good

- Staff treated patients with kindness and respect, and maintained confidentiality throughout our inspection. We observed a patient-centred culture and approach within the practice.
- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated they were treated with compassion, dignity and respect and felt involved in decisions about their care and treatment.
- Data from the latest GP survey showed that patients generally rated the practice in line with local and national averages in respect of care.

Summary of findings

- We were informed of many examples in which staff had provided personalised care and support for individual patients, in response to their needs.
- Feedback from community based health care staff and care home staff was positive with regards to the high standards of care provided by the practice team.
- The practice had identified 2% of their list as being carers, which was in line with expected averages. Information was available on the various types of support available to carers.
- The practice helped raise funds for the local hospice by selling books donated by patients.

Are services responsive to people's needs?

Outstanding

- Comment cards and patients we spoke with during the inspection provided generally positive experiences about obtaining a routine appointment with a GP, or being able to speak to someone regarding their concerns. The latest GP survey showed that patient satisfaction was generally in line with local and national averages with regards access to GP appointments.
- There was in-built flexibility within the appointment system including pre-bookable slots; telephone consultations; and 'on the day' appointments. An advanced nurse practitioner (ANP) triaged requests for same day appointments and provided advice or made arrangements for that patient to be seen by a GP or the ANP. Patient feedback regarding the triage service was generally very positive.
- Urgent appointments were available on the day. The practice offered an extended hours' commuter surgery on one morning and one evening each week.
- Patients could book appointments and order repeat prescriptions on line. The practice participated in the electronic prescribing scheme, so that patients could collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- The practice hosted a range of services on site which made it easier for their patients to access locally. This included ante-natal care; talking therapies for patients with mental health problems; and a Citizens Advice Bureau session.
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.

- The premises provided modern and clean facilities and were well-equipped to treat patients and meet their needs. The practice accommodated the needs of patients with disabilities, including access to the building through automatic doors.
- The practice provided care for residents at two local care homes, and weekly visits were undertaken to each home by the advanced nurse practitioner. Any urgent requests for a consultation were undertaken within 24 hours by a GP.
- Information about how to complain was available. Learning from complaints was shared with staff to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they were offered a more private area to ensure their privacy.
- Flu clinics were made available on Saturday and on some evenings to improve access.

Are services well-led?

Outstanding

- The partners had a strong commitment to delivering high quality care and promoting good outcomes for patients. The practice had a clear vision with quality and safety as its top priority.
- There was a clear staffing structure in place. GPs and ANPs had lead roles providing a source of support and expert advice for their colleagues
- Due to its location on the edge of the High Peak, hospital services were often quite remote for practice patients. The partners had created an independent provider service with two other GP practices which delivered some NHS out-patient services into the community, making these more accessible for local residents. This approach was supportive of the local CCG strategy for 21st century patient care.
- The partners worked collaboratively other GP practices in their locality, and worked proactively with their CCG.
- The partners reviewed comparative data provided by their CCG and ensured actions were implemented to address any areas of outlying performance.
- Staff felt well-supported by management, and the practice held regular staff meetings.
- The practice had developed a wide range of policies and procedures to govern activity.

Summary of findings

- The practice proactively sought feedback from patients, which it acted on to improve service delivery. The practice had an active Patient Participation Group (PPG). This group worked well with the practice, and made suggestions to improve services for patients.
- High standards were promoted and owned by all practice staff who worked together effectively across all roles. There was a strong focus on continuous learning and improvement at all levels.
- The practice used innovative measures to shape service delivery, and we saw a number of initiatives that had impacted positively upon patient care. For example, the work undertaken in relation to sepsis. Some of the schemes developed within the practice had been adopted across a wider area with an impact on both primary and secondary care.
- The practice participated in research projects. For example, they were working with Nottingham University to research the needs and experiences of patients with dementia in rural areas.

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

Outstanding

- The practice had developed a number of in-house services to prevent older patients from travelling to hospitals which were located some miles away with infrequent local public transport provision. The services included blood tests, 24 hour blood pressure and ECG monitoring, and hearing tests. In addition, some NHS out-patient clinics were held in a nearby town including rheumatology and gynaecology, through an independent initiative developed by the practice and two other local GP practices.
- The practice contracted a community matron who managed a 'virtual ward' of vulnerable older patients with the aim of supporting these patients to be cared for in their own homes, and to avoid unnecessary admissions into hospital.
- The practice worked closely with the wider health and care teams to plan and the co-ordinate care to best meet their patients' needs.
- Longer appointment times were available and home visits were available for those unable to attend the surgery.
- An advanced nurse practitioner undertook weekly visits to two local care homes for older patients, one of which specialised in the care of dementia.
- Uptake of the flu vaccination for patients aged over 65 was 69% which was in line with local (73.9%) and national (70.5%) averages.

People with long term conditions

Outstanding

- The practice achieved 99.98% for diabetes QOF related indicators, in line with the local average of 96.7% and above the national average of 89.2%. This was achieved with a marginally lower exception reporting rate at 11.8% (local 13.4%; national 10.8%).
- The practice undertook annual reviews for patients on their long-term conditions registers. For example, 72% of patients with chronic obstructive airways disease (COPD) had received a review of their condition in the last 12 months.
- QOF achievement for 2014-15 for asthma and atrial fibrillation were below the CCG and national averages. However, the practice was able to explain the lower achievement and had developed actions to enhance their performance.

Summary of findings

- The majority of diabetes care was provided in-house and this included the initiation of insulin. A weekly internal multi-disciplinary meeting reviewed complex patients with diabetes. Specialists were occasionally invited to the meeting for training purposes.
- The practice had established a pre-diabetes register and had delivered a programme of support for these patients since March 2016. The aim of this nurse-led programme was to reduce the associated cardiovascular risk factors which could result from diabetes. For example, by educating patients regarding diet, the promotion of an active lifestyle, and the proactive self-management of their condition.
- The partners contracted a community matron to plan and oversee the management of their most vulnerable patients, including those who were at risk of a hospital admission. A practice-employed care co-ordinator worked with other services and agencies to plan and deliver patient care, particularly for those patients being discharged following a hospital admission.
- The practice provided a range of services on site for patients with a long-term condition. This included spirometry (to assess breathing difficulties); foot checks for patients with diabetes; and INR monitoring both at the surgery and in patients' homes. INR testing measures the length of time taken for the blood to clot to ensure that patients taking particular medicines were kept safe.
- A specialist respiratory nurse attended the practice each month to review patients with complex breathing difficulties.

Families, children and young people

Outstanding

- A GP led clinic for six week baby checks was provided at the surgery. This helped to identify any concerns with the baby and to promote the child immunisation programme. It also provided an opportunity to review the parents for issues such as post-natal depression. The midwife held an ante-natal clinic on site every week.
- Childhood immunisation rates were high with rates for the vaccinations given to children at five years of age ranging from 96% to 100% (local average 96.5% to 99.1%).
- The health visitor attended a meeting with the lead GP for child safeguarding once a month to discuss any child safeguarding concerns. Child protection alerts were used on the clinical system to ensure clinicians were able to actively monitor any concerns.

Summary of findings

- Appointments were available outside of school hours.
- Requests for child consultations were prioritised. Telephone advice was offered to parents when required.
- There was an established teenager clinic which provided support on issues such as sexual health, healthy eating, and psychological concerns.
- Family planning services were provided to fit and remove intrauterine devices (coils) and implants, and advice and support was available for all aspects of contraception.
- The practice had baby changing facilities, and provided a low table and chairs with toys for younger children. The practice welcomed mothers who wished to breastfeed on site.

Working age people (including those recently retired and students)

Outstanding

- The practice offered on-line booking for appointments and requests for repeat prescriptions. The practice provided electronic prescribing so that patients on repeat medicines could collect them directly from their preferred pharmacy.
- Extended hours' GP consultations were available at the main site. Early morning and evening appointments were available as a commuter clinic on one day each week to accommodate the needs of working people.
- Clinics for patients with diabetes were held three times each week, including one evening to provide more flexibility for working patients.
- The practice promoted health screening programmes to keep patients safe. Although performance for cervical and breast screening was slightly lower than average figures, the practice was able to explain this and describe how this was being addressed,
- The practice offered health checks for new patients and NHS health checks for patients aged 40-74.
- The practice held a 'Fit and Trim Club' for weight management run by an experienced practice nurse.

People whose circumstances may make them vulnerable

Outstanding

- The practice had searched their clinical system to check for patients who had not been seen by the practice for some time, and reviewed their status. This led to the identification of some vulnerable patients who required support and care planning to keep them safe and well. For example, a patient with learning disability who was managing alone following the death of their carer.

Summary of findings

- The practice had undertaken an annual health review in the last 12 months for 32% of patients with a learning disability. The practice had identified the reasons for this comparatively low achievement and had a plan of action to address this.
- Longer appointments and home visits were offered to vulnerable patients when required. For example, patients with a learning disability might be seen in their home or at a day centre, if attendance at the practice caused them anxiety.
- The practice provided high quality end of life care. Patients with palliative care needs were reviewed at weekly multi-disciplinary team meetings, and had supporting care plans in place. Community nursing staff informed us that the GPs were caring and highly responsive to these patients, and ensured that any needs were acted upon promptly.
- Clinicians attended case conferences and vulnerable adults' review meetings to discuss their most vulnerable patients. We were provided with an example of how vulnerable patients who smoked were at risk from a potential fire. This led to joint working with the local fire service and the installation of sprinkler systems in vulnerable patients' homes.
- Staff had received adult safeguarding training and were aware how to report any concerns relating to vulnerable patients. There was a designated lead GP for adult safeguarding.
- The practice staff had received training from the Alzheimer's Society to become 'Dementia Friends'. This had initiated a successful 'tea dance' event at the end of 2015 attended by patients with dementia and their carers. Over 70 people attended this successful event, which provided excellent support for carers. There were plans to repeat this in the future.

People experiencing poor mental health (including people with dementia)

Outstanding

- The practice achieved 99.4% for mental health related indicators in QOF, which was 1.3% above the CCG and 6.6% above the national averages, with exception reporting rates generally in line with averages.
- 96.2% of patients with poor mental health had a documented care plan during 2014-15. This was 2.9% higher than the CCG average and 7.9% higher than the national average, although exception reporting rates were higher.
- The practice provided access to a cognitive behavioural therapist twice a week at the main site, and once a week at their branch. CBT is a technique used to empower patients to resolve problems by changing their thinking and behaviours.

Summary of findings

- The practice had a lead GP for mental health. The practice had established good links with the mental health care team and crisis team. A community psychiatric nurse (CPN) attended the multi-disciplinary meetings on approximately a monthly basis to review and discuss any patients with ongoing mental health needs.
- Appointments were available on the day for patients experiencing acute mental health difficulties.
- 84.1% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was in line with local and national averages, although the practice had achieved slightly lower exception reporting rates.
- A visiting consultant specialising in older age psychiatry provided memory clinics at the practice once a fortnight. In addition, patients could see an Adult Psychiatrist at the health centre, sited opposite the surgery
- The practice undertook a significant event review in the event of a mental health-related death, or on cases which were deemed appropriate in terms of any lessons learnt.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. A total of 238 survey forms were distributed and 120 were returned, which was a 50% completion rate of those invited to participate.

- 84% of patients found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 84% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 88% and a national average of 85%.
- 70% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 81% of patients found the receptionists at this surgery helpful compared against a CCG average of 89% and a national average of 87%.
- 68% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 71% and a national average of 65%.
- 87% of patients said they would recommend this surgery to someone new to the area compared to a CCG average of 84% and the national average of 78%.

The practice monitored patient feedback and strove to improve on the areas that patients considered problematic with regards access.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 21 comment cards which were all extremely positive in respect of the level of care provided and the interactions with the practice team. Patients said they were treated in a respectful manner and that they had confidence in staff who they considered to be knowledgeable and focused upon their individual needs. Three cards made reference to difficulties in obtaining a GP appointment, however, two of these went on to describe how that was overcome by a very positive experience with the triage service.

All of the 13 patients we spoke with during the inspection said that they were treated with dignity and respect by the practice staff. Patients reported a high level of satisfaction regarding their consultations, stating that they were provided with sufficient consultation time and that they felt treated as individuals.

Care Quality Commission

Sett Valley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Sett Valley Medical Centre

Sett Valley Medical Centre provides care to approximately 10,756 patients in New Mills, a town situated approximately eight miles south east of Stockport in the High Peak area of North Derbyshire. The practice has a branch site based in the small village of Hayfield, located approximately four miles away (The Old Bank Surgery, Market Street, Hayfield, High Peak, Derbyshire. SK22 2EP).

The practice provides primary care medical services via a Personal Medical Services (PMS) contract commissioned by NHS England and North Derbyshire Clinical Commissioning Group (CCG). The main site operates from a purpose-built two storey detached building constructed in 1991. The building was extended in 1993 to add a pharmacy and a dental practice, which are independent providers but the practice retains landlord responsibilities for the whole building.

The practice is run by a partnership of five GPs (three males and two females), and the partners employ a female salaried GP. A second salaried GP is due to start working at the practice in September 2016.

The nursing team comprises of two advanced nurse practitioners, a nurse practitioner, four practice nurses, and two health care assistants. The clinical team is supported by a practice manager, an assistant practice manager and a team of six administrative and reception staff including a reception manager. One of the members of the administration team also works as the practice care co-ordinator. The practice also employs two cleaning staff.

In addition, the practice contracts an independent part-time community matron and independent part-time pharmacist to work at the practice.

The partnership is an established training practice and a GP registrar (a qualified doctor who is completing training to become a GP) works within the practice. It is also a teaching practice and accommodates placements for medical, nursing and midwifery students.

The practice age profile shows slightly higher numbers of patients aged in the 45-70 years range. The registered patient population are predominantly of white British background, and the practice is ranked in the third lowest decile for deprivation status. However, New Mills East is the second most deprived ward within the High Peak area. New Mills is a commuter town for larger areas including Stockport and Manchester, but local employment consists of light industry including a confectionery manufacturer, which is the largest employer in the town. The previous industrial heritage of the town which included textiles and open cast coal mines led to a relatively high prevalence of occupational diseases including lung and cardiovascular related illnesses. The branch site, which is a converted bank, serves a rural community in a small building with one consulting room and one treatment room.

The practice is the most northerly sited practice in the county and is sited some miles from the commissioner's

Detailed findings

base in Chesterfield. Due to its location, the practice has more established links with secondary care providers in Stockport and this can create some difficulties in terms of service configuration and development.

The practice's main site opens from 8am until 6.30pm every Monday, Tuesday, Thursday and Friday. Extended hours opening operates every Wednesday when the practice opens from 6.45am until 8pm. Scheduled GP morning appointments times are available from 9.00am until approximately 11.10am with later appointments being added for 'on the day' consultations further to triage. Afternoon GP surgeries run approximately from 3.45pm to 6.10pm. On Wednesdays, GP and nurse led commuter clinics operate from 6.50am to 9.40am, and from 5.25pm until 7.45pm. The practice closes one Wednesday afternoon on most months of the year for staff training.

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

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

We carried out an announced inspection on 21 July 2016 and during our inspection:

- We spoke with staff including GPs, the practice manager, the assistant practice manager, the reception manager, an advanced practice nurse, practice nurses, a health care assistant and members of the reception and administrative team. In addition, we spoke with representatives from two local care homes, a district nurse, and the independent pharmacist working at the practice regarding their experience of working with the practice team. We also spoke with 13 patients who used the service, and two members of the practice patient participation group.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 21 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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

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

Detailed findings

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)

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- There was a designated lead GP for significant events. This GP and the practice manager had attended a five-day course by the NHS Institute for Innovation and Improvement called Leading Improvement in Safety and Quality (LISQ). This impacted on how the practice dealt with incidents in prioritising patient safety concerns.
- The practice had developed a procedure to define the process for staff to follow. A significant event reporting form was readily accessible to staff. The practice had also devised an additional simplified template for the reporting of low-level incidents to ensure these were reviewed and acted upon, to help prevent a potentially significant occurrence in the future. This form encouraged reporting at all levels as it was less onerous to complete. The practice encouraged staff to report incidents within a supportive 'no blame' culture.
- Clinical incidents were reviewed by the lead GP, whilst the practice manager reviewed administrative incidents to determine the level of risk and consider any immediate actions required. The practice discussed incidents at either clinical or general staff meetings which were held monthly, and those with wider learning were shared across all staff groups.
- We observed that incidents forms were completed appropriately with evidence of any agreed actions being completed.
- People received support, information, an apology when there had been unintended or unexpected safety incidents. They were told about any actions taken to prevent the same thing happening again.

A total of 14 significant events had been recorded by the practice team over the preceding 12 month period. Learning points were identified to improve safety in the practice. For example, a review of a patient death identified the needs for more robust communication methods with the community mental health crisis team, including the use of secure email. The practice had undertaken the review of this incident with other providers who had been involved in supporting the patient. This ensured a collaborative approach with learning across services.

The practice had a process to review alerts received including those from the Medicines Health and Regulatory Authority (MHRA). When concerns were raised about specific medicines, patient searches were undertaken to identify which patients may be affected. Effective action was then taken by clinicians to ensure patients were safe, for example, by reviewing their prescribed medicines. We saw evidence of an audit done by the pharmacist that had been instigated further to the receipt of a specific MHRA alert.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local guidance and policies were accessible to staff. Practice safeguarding policies were accessible and up-to-date, and alerts were used on the patient record to identify any vulnerable children to ensure staff were aware of the need to actively monitor any new concerns. There were lead GPs for safeguarding both children and adults, and both had received training at the appropriate level in support of these roles. The health visitor attended a monthly meeting with the child safeguarding lead GP to discuss any child safeguarding concerns. The cases discussed were documented directly into the patients' electronic record during the meeting. Practice staff demonstrated they understood their responsibilities and all had received training relevant to their role, including an adult safeguarding training event held at the practice in May 2016.
- The practice had worked in collaboration with the UK Sepsis Trust over the last 18 months to promote the awareness and treatment of sepsis in primary care. This recognised that the early identification of symptoms and the use of effective safety netting was paramount within the primary care setting. The practice had been influential in sharing best practice with other local practices. Their work had received acknowledgment through publication in a national medical journal.
- A notice in the reception and the consulting rooms advised patients that a chaperone could be made available for examinations upon request. Members of the reception and administration team had undertaken

on-line and face-to-face training in support of this role. They acted as chaperones if this was requested, when a clinical member of staff was unavailable. Staff who undertook chaperoning duties had received a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). A practice chaperone policy was available.

- We observed that the practice was tidy and maintained to good standards of cleanliness and hygiene. An advanced nurse practitioner was the appointed infection control lead. Links had been established with the local community infection control and prevention team, and the microbiology team at the hospital in Stockport. There were infection control policies in place, which had been reviewed regularly. Practice staff had received infection control training and received information as part of new staff inductions. A handwashing audit was being arranged for the practice team. Infection control audits were undertaken regularly (most recently in November 2015), and we saw evidence that recommendations had been made as a result of this, which were being formalised into an action plan. The practice employed two cleaners supported by a relief team to provide cleaning services. A written schedule of cleaning tasks was not available, and arrangements in place to monitor cleaning standards were informal and reviewed by general observation.
- We reviewed four staff files and found that recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.
- The practice had a robust system to manage incoming correspondence to ensure that any actions, such as a change to a patient's medicines, were completed promptly. Staff understood the process in place and we saw that correspondence was up to date on the day of our inspection.

Medicines management

- The arrangements for managing medicines in the practice, including emergency medicines and vaccinations, kept patients safe. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Monthly medicines stock checks including expiry dates were undertaken and we saw documented evidence of this. Signed and up-to-date Patient Group Directions were in place to allow nurses to administer medicines in line with legislation, and healthcare assistants administered medicines against a patient specific prescription or direction from a prescriber. Nurse prescribers received support and mentorship from a designated GP prescribing lead.
- There were systems to regularly monitor patients prescribed high-risk medicines, and we were informed of procedures to monitor any uncollected prescriptions and follow this up with the patients concerned.

Monitoring risks to patients and staff

- There was a health and safety policy available. There were some generic risk assessments within the practice's business continuity plan, and others such as the control of substances hazardous to health. Risk assessments were not being used proactively to manage any new or emerging risk areas.
- The practice had received a fire safety risk assessment covering both sites, and the actions identified from this had been completed. This included their responsibilities as property owners for the attached pharmacy and dental practice. Staff had received regular fire training, and the practice had undertaken evacuations to ensure staff were aware of the procedure to follow in the event of a fire.
- All electrical equipment was regularly inspected to ensure it was safe to use, and medical equipment was calibrated and checked to ensure it was working effectively. We saw certification that this had been completed by external contractors in the last 12 months.
- A formal assessment for legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings) had been recently completed in conjunction with Public Health England.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. We were provided with examples of how the team worked flexibly to ensure adequate cover was available at all times.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

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

- Staff had received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.
- There was an instant messaging system on the computers in all the consultation and treatment rooms and patient areas, which alerted staff to any emergency.
- The practice had dealt with medical emergencies on site and took rapid and effective action to provide patients with the immediate life-support and care they required. The paramedic team had complimented the practice for their care and intervention with a patient following a collapse in the surgery.
- The practice had a business continuity plan for major incidents such as power failure or building damage. Copies of the plan were kept off site in case any incidents made entry to the site inaccessible, and alternative locations had been considered as a contingency to provide temporary accommodation. The plan was reviewed regularly with the most recent update in July 2016.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, and local guidance, for example, in relation to prescribing.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 94.9% of the total number of points available. This had been achieved with exception reporting rates at 9.7%, compared to a local average of 11% and national average of 9.2%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. The procedure followed by staff to follow up patients prior to exception reporting them was appropriate.

QOF data from 2014-15 showed:

- Performance for diabetes related indicators was 99.98% which was comparable to the CCG average of 96.7% and above the national average of 89.2%. Exception reporting for diabetes related indicators at 11.8% was slightly below the CCG average of 13.4%, and marginally above the national average of 10.8%.
- 85.4% of patients with hypertension had regular blood pressure tests. This was in line with the CCG average of 85.3%, and the national average of 83.6%.
- QOF achievement for 2014-15 for asthma was 76.9% which was below the CCG average of 97.6%, and the national average of 97.4%, although exception reporting rates were significantly lower. However, the practice was able to explain the lower achievement as their practice lead nurse for asthma had left, and the new nurse had needed to undertake additional training in support of this role. This training had been completed and we saw data that demonstrated an increase to 79%
- The practice achieved 64.7% for indicators related to atrial fibrillation (an irregular heart rate). This was significantly below the CCG average of 98.7%, and the national average of 98.5%. However, the practice were able to provide updated figures (although these had not externally verified) that showed they were now performing in line with averages.

Practice held data, which has not yet been verified, demonstrated that high QOF achievement had increased to 99% for 2015-16.

There was evidence of quality improvement including a programme of clinical audit.

- We saw evidence of seven clinical audits undertaken in the last year. One of these was a completed full cycle clinical audit where changes were implemented and monitored with positive outcomes for patients. We reviewed a full cycle audit on the use of novel oral anticoagulants (NOACs) for patients with atrial fibrillation. These medicines are effective in helping to prevent complications such as strokes and do not require stringent monitoring including regular blood tests. The second audit demonstrated an improvement in compliance with NICE clinical knowledge summaries, and identified ways that performance could be further improved. This provided further assurance on the practice's published QOF performance for this condition.
- The practice worked closely with the CCG medicines management pharmacy technicians who visited fortnightly and carried out medicines audits to ensure prescribing was cost effective, and adhered to local guidance. This was further enhanced by the practice having access to a pharmacist contracted to work for three days each week. Total antibiotic prescribing was the fifth lowest across the CCG's 36 GP practices. Prescribing costs were below local averages, and the latest data showed the prescribing budget was underspent by 7.3%.
- The practice participated in local benchmarking activities. For example, the practice undertook a review of data provided by their CCG including referral rates and hospital admissions.

Effective staffing

- The practice had established an effective clinical skill mix within their team. Advanced nurse practitioners (ANPs) and a nurse practitioner complimented the work

of the GPs, and provided autonomy for these nurses to see patients with a wider range of presentations and to prescribe some medicines directly. ANPs had lead areas including weekly visits to two local care homes, and this alleviated some of the pressures on the GP's time. The practice contracted a pharmacist three days each week. The pharmacist assisted in the early identification of any medicines' issues, and provided general support with regards prescribing matters. For example, the pharmacist had visited an elderly patient with multiple conditions at home and sorted out their medicines regime which had become confused. This led to improvements in the patient's well-being. A community matron was contracted to manage older vulnerable patients to avoid their admission into hospital, and we were provided with examples of how some patients had been effectively managed with the development of a robust care plan supported by regular contact and intervention.

- The practice had developed induction programmes for all newly appointed staff. This incorporated relevant topics for new staff, and we saw evidence of completed induction programmes, although these were not routinely stored in staff files.
- The practice ensured role-specific training with updates was undertaken for relevant staff e.g. administering vaccinations and taking samples for the cervical screening programme.
- Staff had received an annual appraisal, which was undertaken by the practice manager in conjunction with either a GP or nurse. We saw documentation that demonstrated a comprehensive process. We spoke to members of the team who informed us of how learning opportunities had been discussed during the appraisal and supported by the practice. For example, a practice nurse told us how they had been supported to attend a number of courses to develop their clinical skills and knowledge. The practice had given a former apprentice a permanent contract and were providing them with financial support and time to gain additional qualifications at a local college.
- Staff received mandatory training that included safeguarding, fire safety awareness, and basic life support. Staff had access to and made use of e-learning training modules and in-house training. The practice had protected learning time on one afternoon each month, and in-house training was arranged for the practice team. GPs attended training events organised by their CCG on some of these months.
- Nurses received support in their roles, and to prepare for revalidation. For example, the advanced nurse practitioners were able to access mentorship and advice from GPs in relation to their independent prescribing status. The lead practice nurse met weekly with the practice manager.
- The GP registrar provided a statement praising the practice team for their support, and the commitment given to support their ongoing professional development. The registrar described receiving 'an excellent training experience' from the two GP trainers, including a good induction followed by a programme of supportive teaching and access to advice.

Coordinating patient care and information sharing.

- The information needed to plan and deliver care and treatment was available to clinicians in a timely and accessible way through the practice's electronic patient record system. This included care plans, medical records, and investigation and test results.
- The practice team worked collaboratively with other health and social care professionals to assess the range and complexity of patients' needs, and plan ongoing care and treatment. Weekly multi-disciplinary meetings were held between practice clinicians and representatives from a wide range of professionals including district nurses, social services, the community psychiatric nurse, and the Macmillan nurse. The meetings focused upon vulnerable patients (including those at high risk of hospital admission); patients with end of life needs; and patients in care homes. Electronic patient records were updated to reflect discussions and any agreed action points following the meeting. Numbers of unplanned hospital admissions were comparable to local and national averages.
- A weekly diabetes multi-disciplinary practice team meeting included a GP, ANP, senior practice nurse and occasionally health care assistants. Complex cases were discussed including poor control of diabetes, and treatmentoptions and plans. Outside specialists were invited to attend on occasions to promote new learning and to teach new skills.

Good

Are services effective?

(for example, treatment is effective)

- Clinical staff met together informally at the end of each morning, and this offered an opportunity to share information, and to resolve any issues that had arisen that day.

Consent to care and treatment

- Staff sought patients' consent to care and treatment in line with legislation and guidance. Consent was recorded for any invasive procedures including coil fittings and minor surgical procedures. An audit of the vasectomy service demonstrated 100% compliance in documenting patient consent.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff followed national guidelines to assist clinicians in deciding whether or not to give sexual health advice to young people without parental consent.

Supporting patients to live healthier lives

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

- The practice had developed a comprehensive package of care to support their patients with diabetes. A weekly multi-disciplinary practice team meetingtook place to discuss and review complex cases including poor control of diabetes, and treatment options and plans. Outside specialists were invited to attend and deliver teaching including injection devices. In addition, the practice had created their own in-house service for patients with signs of pre-diabetes from March 2016. The aim of this programme was to reduce the associated cardiovascular risk factors which can result from diabetes. For example, by educating patients regarding diet, the promotion of an active lifestyle, and the proactive self-management of their condition. The practice had identified 237 pre-diabetic patients and most had been contacted and seen at the surgery within the last six months. A comprehensive audit was planned for this group of patients to identify the full outcomes achieved from this work.
- The practice referred relevant patients for advice on healthier lifestyles, including services to help patients stop smoking and to control alcohol intake.
- The practice held a 'Fit and Trim Club' for weight management run by an experienced practice nurse, and patients could also be referred to the local leisure centre as part of the GP 'exercise by prescription' scheme.
- The practice provided health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.
- An annual health review had been undertaken for 32% of patients with a learning disability. The practice had investigated their performance and subsequently reorganised their recall system in order to improve. For example, the practice would place more emphasis on engaging with people with learning disabilities and their carers when contacting them for reviews; a practice nurse had been given lead responsibility for leading the reviews; and liaison took place with the local service provider for patients with learning disabilities. The annual reviews would be undertaken in the patient's home or at a day centre if attending the practice caused them anxiety.

The practice's uptake for the cervical screening programme was 79.4%, which was slightly below the local CCG average of 84.1%, and national average of 81.8%. However, the practice had lower exception reporting rates at 1.3% (CCG 2.9%; national 6%). National screening programme data showed the uptake for bowel screening was generally in line with local and national averages, but breast screening was lower. The practice explained that due to commissioning arrangements, patients had to access breast screening at Chesterfield which was a long journey, and many were therefore unwilling to attend. Patients were no longer able to access the service based at Stockport which was much nearer to them. Because of the rural location, a mobile screening unit would be sited by the surgery for the month of August and this would help address access problems for local patients. The practice was planning an awareness campaign later in the year.

Childhood immunisation rates for the vaccinations given to children aged up to five years of age were high. The overall childhood immunisation rates for the vaccinations given to under two year olds ranged from 93.4% to 98.9% (local average 95.2% to 98.9%) and five year olds from 96% to 100% (local average 96.5% to 99.1%).

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

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

Patients we spoke with told us they were listened to and supported by staff, and felt they were treated with compassion, dignity and respect by clinicians. Results from the national GP patient survey in July 2016 showed the practice was in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the CCG average of 91% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90%, and the national average of 85%.

Staff at two local care homes covered by the practice informed us that their residents received good care from the practice. We also spoke with a member of the district nursing team who reported that the GPs were patient-centred, approachable and respectful of their opinions.

We were provided with examples of how individual patients' needs had been met, and we saw a selection of letters from patients expressing their gratitude for the care they had received.

Care planning and involvement in decisions about care and treatment

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

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

- 93% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and above the national average of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87%, and above the national average of 82%.

Patient and carer support to cope emotionally with care and treatment

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

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 2% of the practice list as carers, and identified new carers upon registration. The local carers association had attended the practice to promote carer support, and the practice were formalising the role of the care co-ordinator to become a designated practice 'Carers' Champion'.

A patient tea dance took place in November 2015. This was initiated by the practice team after dementia friends training highlighted that they needed to consider different approaches towards this patient group. The issue of social isolation amongst patients with dementia and their carers was a particular feature that practice staff chose to target. Plans were developed for a coffee morning but staff evolved this into a whole event with bands, stands and cakes hosted by the local leisure centre. The event was attended by the Alzheimer's Society, patient participation group, police, ambulance and day centre staff and community psychiatric nurses. The volunteer centre

Good

Are services caring?

provided minibus transport to help people attend the event. Approximately 70 patients and carers attended this event, and this was so well received that the practice hoped to repeat this in the future.

The practice worked to high quality standards for end of life care to ensure that patient wishes were clear, and that they were involved in the planning of their own care. GPs would usually contact or visit relatives following a patient death to offer condolences, and signpost them to appropriate services such as counselling, if required.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG), to secure improvements to services where these were identified. For example, the practice provided a vasectomy service as part of the any qualified provider (AQP) scheme. This service operated as a 'one stop clinic' with the counselling and procedure undertaken at the same time. This enabled patients from other practices to access this service, commissioned with the intention of improving patient choice and access to local treatment.
- The practice had formed an independent company with two other local GP practices that provided a range of out-patient and diagnostic services locally. This included NHS out-patient clinics such as dermatology, ophthalmology, gynaecology and an ultrasound diagnostic service. This facility enabled patients to access high quality health care within the High Peak area and avoided long journeys to hospitals, which were located several miles away.
- The practice provided a range of services that ensured these were easily accessible for their patients. This included blood tests, 24 hour blood pressure and ECG monitoring, spirometry (a test to assess breathing), travel vaccinations; and performed some minor operations.
- The practice contracted a pharmacist and a community matron to work within the practice. These roles respectively provided expert medicines advice and support; and leadership and management for vulnerable patients with complex needs in their own homes.
- The premises were purpose built and offered a pleasant environment for patients. All healthcare services were delivered on the ground floor. There was good access for patients with reduced mobility, and access to both a fixed and portable hearing loop system. The practice was aware that further work was needed to ensure full compliance with the Equality Act, and was arranging to have a section of the reception desk lowered to improve interaction with patients in a wheelchair or mobility scooter.
- A branch surgery was provided in Hayfield, approximately four miles away. This served a predominantly rural community and provided better access for older patients due to the limited local public transport.
- The building incorporated an independent dental practice and a pharmacy, which enabled patients to receive better co-ordinated care. For example, when collecting prescribed medicines from the pharmacy.
- The practice was situated opposite a health centre and the out of hours' base, and a local leisure centre. This helped communication with community based health staff, and patients could access services including physiotherapy and podiatry at the health centre. It was also useful for links such as the GP exercise by prescription scheme which could be accessed at the leisure centre.
- The waiting area contained a good range of information on services and support groups. Health promotion material was displayed and notice boards were well-maintained and included useful information.
- A touch screen log in facility was available for patients to book in upon arrival at the surgery, and an electronic message board displayed appointments and information.
- The layout of the reception area provided good confidentially for patients. In addition, patients could be moved into a nearby free consulting room, or to a quieter area at the side of reception with a partition screen, if necessary for private discussions.
- The practice hosted a number of services on site to facilitate better access for patients. This included talking therapies for mental health; ante-natal clinics with the midwife; and the Citizens Advice Bureau.
- The practice had a slit-lamp which could be used to examine and diagnose eye conditions. A GP and advanced nurse practitioner were trained to use this specialist equipment which enabled patient to receive better access to the care they required. The practice also had an audiometer for hearing tests.
- Longer appointments could be booked for those patients with more complex needs. Home visits were available for older patients and others with appropriate clinical needs which resulted in difficulty attending the practice. Same day appointments were available for children and those patients with medical problems that required them to be seen urgently.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

- The practice provided care for residents at two local care homes. An advanced nurse practitioner routinely visited each home weekly to review patients, and any urgent requirements were responded to by a GP. We received some mixed views regarding the responsiveness from the practice to each home, but overall the opinion favoured that residents received timely care.
- The surgery produced a quarterly patient newsletter to provide updates about the practice, and information on services. The practice website was up to date and acted as a useful source of information for patients.
- Translation services were available for patients whose first language was not English. The practice had identified that one of the local industries had appointed a number of Eastern European workers.

Access to the service

The practice opened from 8am until 6.30pm every Monday, Tuesday, Thursday and Friday. Extended consulting hours opening were available every Wednesday when the practice opened from 6.45am until 8pm.

Scheduled GP morning appointments times were usually available from 9.00am until approximately 11.10am. Patients requiring to be seen on the day were triaged by an advanced nurse practitioner and any patient needing to see a GP urgently was booked directly into designated appointments slots at the end of the morning surgery. Alternatively, the ANP might arrange to see the patient. Afternoon GP surgeries ran from 3.45pm to 6.10pm approximately. On Wednesdays, GP and nurse led commuter clinics were provided from 6.50am to 9.40am, and from 5.25pm until 7.45pm. The practice closed one Wednesday afternoon on most months for staff training.

Patients could book appointments and order repeat prescriptions on line. The practice participated in the electronic prescription service, enabling patients to collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.

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

- 84% of patients said they could get through easily to the practice by phone which was above the CCG average of 77%, and higher than the national average of 73%.
- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 70% of patients described their experience of making an appointment as good compared to a CCG average of 76% and a national average of 73%.
- 60% of patients usually got to see or speak to their preferred GP, which was the same as the local average and 1% higher than the national average. This was reinforced by patients we spoke with on the day who also said that their request to see a female or male GP conditions had been accommodated.

Staff informed us that patients could book ahead up to six weeks in advance to see a GP, and eight weeks for a nurse appointment. On the day of our inspection, we saw that the next available routine GP appointment was available in two days' time. Ongoing audits of capacity and demand were undertaken, and action was taken as appropriate to respond to this – for example, additional GP sessions or the use of a locum GP. The majority of patients we spoke with on the day, and feedback received on a number of comment cards, generally expressed satisfaction with the appointment system.

Good access had impacted positively on A&E attendance (250 per 1,000 patients compared against the CCG average figure of 270). This was the lowest figure across the eight GP practices in the High Peak.

Listening and learning from concerns and complaints

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

- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated person who dealt with complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the waiting area.

We looked at a selection of complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. The practice offered to meet with complainants to discuss their concerns whenever appropriate. Complaints were

considered at the weekly partners meeting. Lessons were learnt and shared with the team following concerns and complaints, and action was taken to as a result to improve the quality of care.

Are services well-led?

Outstanding

(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 vision to deliver high quality care and promote good outcomes for patients.

- The service had clear aims and objectives. These included a focus on a patient centred approach with an aim to provide services locally so that patients did not have to travel.
- The practice held a partners' meeting each week. This reviewed key issues relating to the practice business. The practice manager summarised the discussions via email to all partners to ensure that any who were unable to attend the meetings were kept updated. In addition, the partners and practice manager held an evening meeting approximately three times each year to focus on strategic issues and forward planning. These meetings were documented.
- Whilst the practice did not have a written business plan, the partners and management had a clear vision. They were mindful of the need for a more collaborative approach and engaged well with other practices in their area and the CCG to plan and share best practice. Due to their location as the most northerly located practice in Derbyshire, their relationship with secondary care was more focused upon Stockport. Whilst this created some potential difficulties as their service commissioning arrangements were centred on North Derbyshire, we saw that the practice had worked with the secondary care provider in Stockport to discuss and successfully resolve problems which had arisen.
- There was a proactive approach to succession planning across all staff groups. The practice had gone through a recent difficult period with the loss of a salaried GP and the retirement of two long-term GP partners. However, this period had been managed with effective leadership without an impact on the level of patient care provided. Two new GP partners had been recruited and a new salaried GP was due to commence work in September 2016. This was a notable achievement due to the ongoing difficulties regarding GP recruitment nationally.

Governance arrangements

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

- There was a clear team structure in place, and staff were aware of their own roles and responsibilities. GPs had defined lead areas of responsibility, including significant events, diabetes, and CCG liaison, and they acted as an expert resource for their colleagues.
- Systems were in place for identifying, recording and managing risk, and implementing mitigating actions.
- A wide range of practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained. This included analysis and benchmarking of QOF performance, and referral and prescribing data. Actions were undertaken when any variances were identified. It was noted that the practice was a low referrer to most hospital based specialties.

A programme of clinical audit was used to review services and to drive improvements when necessary to enhance outcomes for patients.

Leadership and culture

- The partners engaged regularly with their CCG and worked with them to enhance patient care and experience. For example, representatives attended a CCG event 'Pride and Niggles' in July 2016 to share ideas and best practice. The practice manager attended the local practice managers' meetings.
- The partners and practice management demonstrated they had the experience and capability to run the practice effectively to ensure high quality care. The practice manager had completed a leadership course as part of ongoing professional development within the role. Staff told us there was an open culture within the practice and said the partners and practice manager were approachable, and always took the time to listen to all members of staff. Staff told us that they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Support was provided to the branch surgery as staff rotated between sites, and reported any concerns back to the practice management.
- Staff told us the practice held monthly practice team meetings. These were held when the practice closed for training on one afternoon each month. Minutes of this meeting were documented.
- The practice had a low turnover of staff, and the staff we spoke with told us that it was a good place to work, and the team supported each other to complete tasks. Each

year, staff participated in an annual walk as part of a team building event. Social events took place periodically which supported a strong team spirit within the practice.

- Staff said they felt respected, valued and supported, by the partners and managers in the practice. We were provided with examples of how staff had been supported by the practice, for example, a custom-made raised desk had been provided at the request of staff, which made their working environment more comfortable.

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

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

- The practice had gathered feedback from patients through patient surveys and on the NHS Choices website; via complaints received; a suggestion box; and responses received as part of the Families and Friends Test (FFT). The FFT is a simple feedback card introduced in 2013 to assess how satisfied patients are with the care they received. A FFT report from April 2016 indicated 85% of 152 patient completing the survey would be 'extremely likely' or 'likely' to recommend the practice to their family or friends.
- The patient participation group (PPG) met bi-monthly, and had a membership of approximately 12 core members who regularly attended meetings. The Practice Manager and a GP partner attended these meetings, and a member of the administration team took minutes which were available on the practice website. There was a designated display board for the PPG within the main waiting area. The PPG had organised patient surveys and made suggestions to improve patient experience. For example, the practice had introduced a same-day appointment system but patients did not like it. The PPG made representations to the practice, who then agreed to abandon this arrangement.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

- The practice had extended their building to accommodate an independent pharmacy and dental practice, creating an integral local health facility for patients. This was further enhanced by the practice's co-location with the health centre and local out of hours' unit.
- The practice actively contributed to the CCG's 21st Century work plans which facilitated new ways of working and promoted a shift of some services into the community from a traditional hospital base. The practice had established an independent health provider unit with two other local practices which enabled access to a range of local services for patients, thereby avoiding long journeys to units at Stockport, Macclesfield or Chesterfield. This included a number of NHS out-patient clinics including dermatology and rheumatology, along with ultrasound diagnostic clinic.
- The practice provided a vasectomy service as part of the any qualified provider (AQP) scheme. This service operated as a 'one stop clinic' with the counselling and procedure undertaken at the same time. This enabled patients from other practices to access this service, commissioned with the intention of improving patient choice and access to local treatment.
- The practice had piloted an in-house centrifuge service for bloods. This was developed in response to the requirement for bloods to be analysed promptly, which was sometimes difficult due to the practice's location. In the 12 months prior to the pilot, five patients were admitted to hospital with high potassium, although two of these were found to have normal results when re-tested upon admission. Results from a practice three month pre-centrifuge audit showed that of eight raised readings, six returned as normal on repeat sampling. In the three-month period of the pilot, there were two true raised potassium readings, with no false results and no hospital admissions. The practice was planning a formal audit involving the local Consultant Biochemist to look at the value of installing a centrifuge in a rural practice, with a view to presenting this to the commissioners in support of funding
- The practice had worked in collaboration with the UK Sepsis Trust over the last 18 months to promote the awareness and treatment of sepsis in primary care. This recognised that the early identification of symptoms and the use of effective safety netting was paramount within the primary care setting. This had led to the publication of an article written by the advanced nurse

practitioner in the British Journal of General practice in March 2016. A second project was underway to assess GP perception and knowledge of sepsis prior to the publication of NICE guidance on sepsis in July 2016. The ANP and GPs delivered training on sepsis to other primary care colleagues within their area, and aspired to influence a national sepsis promotional campaign.

- The practice had developed their own in-house service for patients with symptoms of pre-diabetes. The aim of this programme was to delay or prevent progression to diabetes with its associated cardiovascular risks. This commenced in March 2016, and an audit was planned to assess the outcomes achieved.
- The practice had undertaken a project to standardise the way that suspected urinary tract infections were treated based on Health Protection Agency guidelines. The practice had contacted their local hospital and it was noted that a number of urine samples were being received by the laboratory for culture which were not necessary. This led to the hospital based microbiologist delivering a teaching session to the practice including members of the district nursing team and care home and day centre representatives. The outcome was a decrease in the number of inappropriate samples being sent for urinalysis by one third (from 64 patients per 1,000 population to 42), and identified the practice as having one of the highest proportions of appropriate rationale for requests. This produced a cost saving, and access to the microbiologist for advice was made available. The project was rolled out across other local practices in the High Peak and also into the neighbouring practices in Stockport.
- The practice participated in research projects. For example, there was an ongoing involvement in a project ‘Scaling the Peaks’ with the University of Nottingham. This was looking at the needs and experiences of patients with dementia who lived in rural areas.