Darley Dale Medical Centre

Quality Report

The Darley Dale Medical Centre
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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?	Outstanding
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Darley Dale Medical Centre on 08 October 2014, as part of our new comprehensive inspection programme.

We visited the main surgery in Darley Dale. The practice had previously been inspected on 23 January 2014 and was found to be compliant with all regulations. For this reason, we did not visit the branch surgeries in Winster and Youlgreave.

Overall the practice is rated as good. Specifically, we found the practice to be outstanding for providing responsive services; and it was good for providing safe, effective, caring and well-led services. It was also good for providing services to all six population groups we inspected.

Our key findings were as follows:

- Patients were complimentary of the care they had received and reported being treated with dignity and respect. They expressed a high level of satisfaction with the arrangements in place for accessing the service and involvement in decision making.
- The practice had reliable safety systems including safeguarding, medicines management, risk management and infection and control.
- GPs and nursing staff assessed patients' needs in line with NICE guidelines and best practice.
- Ongoing quality improvement work such as clinical audits, peer reviews and benchmarking was promoted to ensure improvements were made to patient care and staff knowledge.
- The appointment system and staffing arrangements were responsive to the needs of the patients. This ensured most patients were able to access same day and emergency appointments.
- The practice offered a variety of in-house services for each of the population group we inspected and these were managed effectively.
- The practice was well led, and both staff and patient feedback was acted upon to improve the service.

We saw several areas of outstanding practice including:

- High patient satisfaction levels in relation to phone access, opening hours and a good overall experience

Summary of findings

of making an appointment. The 2013/14 Public Health England and the national patient surveys showed the practice values were above the regional and national average.

- The practice's involvement with community hospitals allowed the clinicians to provide care throughout the 'patient journey' and when their health needs increased. For example, patients receiving end of life care, management of acute illness and rehabilitation following a hip replacement. This was valued by patients and their carers as it allowed care to be provided close to home and an admission to the acute trust hospital was avoided.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Patients we spoke with told us they felt safe when using the service. We found the practice had suitable arrangements in place for recording and monitoring safety incidents to improve patient care.

Staff we spoke with understood their responsibilities to raise concerns, and report incidents and near misses. Lessons learnt from incidents were communicated to all practice staff to support the improvement of the service.

There were reliable safety systems relating to the following areas: safeguarding of children and vulnerable adults, medicines management, cleanliness and infection control.

The practice equipment was regularly tested and maintained to ensure it remained safe for use. The practice had carried out appropriate recruitment checks before staff were employed and worked to ensure patients were cared for by sufficient staff.

The practice had suitable systems in place for responding to identified risks to patients and their changing health needs. A business continuity plan was also in place to deal with a range of emergencies that could affect the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

Patient needs were assessed and care was planned and delivered in line with current legislation. We found systems were in place to ensure that all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and locally agreed guidelines.

We found these guidelines were influencing and improving patient outcomes and the delivery of services. Data reviewed showed the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group; and nationally in most areas.

Effective staffing arrangements were in place to ensure staff received supervision through peer support, training, appraisals and regular team meetings. Patient information was shared with other providers in a secure and timely manner. The practice offered a wide range of health promotion and prevention services and information was available to patients.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

All but one of the seven patients we spoke with told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. This was also reflected in the national patient surveys undertaken by NHS England and Public Health England.

The survey results showed patients rated the practice higher than the national average in areas such as involvement in decisions about care and being treated with care and concern. 97% of respondents to the national GP Patient survey described the overall experience of their GP surgery as fairly / very good and about 95% would recommend their practice to others. We found the practice had also been awarded the Derbyshire Dignity Award in 2013.

We observed a patient centred culture and found staff were committed to offering kind and compassionate care in line with the practice's vision. We found care plans had been discussed and agreed with the patient, their family and / or other providers to ensure personalised care. The practice had systems in place to support patients cope with their care and treatment. Information relating to support groups for carers and bereavement were also made available to patients.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

Patients we spoke with and the comment cards we received complimented the practice on the: availability of same day appointments, good access to the practice, a named GP or GP of choice, and continuity of care. The 2013/14 Public Health England and the national patient surveys also showed high patient satisfaction results in relation to phone access, opening hours and a good overall experience of making an appointment.

We found the practice understood the needs of its practice population groups and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

The practice facilitated weekly multi-disciplinary meetings and extensive care planning arrangements to meet the needs of different population groups. This included patients with long term conditions, severe mental illness and palliative care and patients at risk of hospital admission.

Summary of findings

The practice took account of patient's different care needs / disabilities and made provisions to promote equal access to the practice. The practice had made changes to the way it delivered services as a consequence of feedback from the Patient Representation Group (PRG). The PRG is made up of patients and staff, and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice.

We found an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised and shared learning with staff.

Are services well-led?

Good

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

The practice had a clear vision in place to deliver high quality services and provide person centred care for its patients and staff were aware of their responsibilities. The strategy to deliver this vision had been produced in consultation with patients, staff and external stakeholders; and was regularly reviewed to assess the practice's progress.

The practice had an active patient representative group (PRG) and was accountable to it for the delivery of its vision. The PRG is made up of patients and staff, and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice. The members of the PRG we spoke with felt the practice was well led and the leadership listened and acted upon their views.

We found Darley Dale Medical practice had designed Quality Outcomes Framework (QOF) templates for recording vital patient information on chronic diseases. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care.

This template was shared with providers of GP computer systems (EMIS and SystmOne) and over 40 practices in Derbyshire to help improve the quality of their QOF work. This demonstrated a practice that was not only innovative but also shared good practice with others.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the population group of older people.

We found the practice offered proactive and personalised care to meet the needs of the older people. For example, the practice's role at the community hospital (Whitworth) allowed the clinicians to continue patient care when their needs increased and were admitted to hospital.

Patients receiving end of life care, management of acute illness and rehabilitation following a hip replacement were also seen by their regular GP therefore ensuring continuity of care. We found all care arrangements for patients on the palliative care register were reviewed each week including urgent admission data.

There were effective systems in place for the assessment and care planning of older people's care needs. This included patients living in nursing homes, receiving end of life care and right care plans which were shared with out of hours services.

The practice held weekly multidisciplinary team meetings with other health and social care professionals as part of a co-ordinated approach to reviewing and monitoring patient care needs. This was also promoted by the close working relationship with the community matron, district nurses and care coordinator working onsite.

All patients aged 75 and over had a named GP and structured annual reviews to check their health and medication needs were being met. The practice was responsive to the needs of older people, including offering home visits, community hospital support, memory testing and opportunistic vaccinations as part of health promotion.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions.

The practice provided an enhanced service to Whitworth hospital in particular the inpatient services for hip replacement and rehabilitation. The benefits of this service to registered patients included a continuity of care for patients as they were seen by their regular GP.

Summary of findings

The practice had extensive care planning arrangements in place including the delivery of multi-disciplinary packages of care. We saw examples of individualised care plans (right care plan, personal care plan and care home care plan) including admission avoidance plans for patients with complex needs. These were reviewed every three months and / or when a patient's individual needs changed.

The GPs used best practice guidelines to inform better diagnosis and treatment of patients with long term conditions. Clinical audits were also used to monitor outcomes relating to patient care and medicines.

The practice maintained a register for patients with long term conditions and effective recall systems were in place for inviting patients for their annual review checks. This included patients with conditions such as asthma, diabetes, chronic obstructive pulmonary disease (COPD), hypertension and chronic kidney disease.

The practice had designed Quality Outcomes Framework (QOF) templates for recording vital patient information on chronic diseases. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. This template was shared with providers of GP computer systems (EMIS and SystmOne) and over 40 practices in Derbyshire to help improve the quality of their QOF work.

The practice also offered nurse led clinics for INR monitoring, insulin initiation and in-house phlebotomy. International normalisation ratio (INR) is used to measure how well your warfarin is working; and blood samples from patients who have been identified as needing a blood test are taken in phlebotomy clinics. Meeting minutes showed the practice had close working arrangements with the community matron, heart failure nurses and respiratory team to improve patient outcomes.

Emergency processes were in place and referrals were made for patients who had a sudden deterioration in health. The practice was responsive to the needs of people with long term conditions, including offering carer support, telephone consultations and health promotion services.

Families, children and young people

Good

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

We saw good examples of joint working arrangements between the practice, health visitors and school nurses to ensure the safety of patients. This included participation in Wednesday clinic meetings, monthly safeguarding meetings and multi-agency team referrals.

Summary of findings

Effective systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children with a high number of A&E attendances, or who did not attend their planned appointments and where there were concerns related to their developmental needs.

The practice had achieved high immunisation rates for all standard childhood immunisations, in comparison to other practices within the CCG area. For example, all of the practice's 24 month old children had received their vaccinations for MMR, Meningitis C and booster. Where immunisation rates fell below 100%, the practice had follow-up systems in place to engage parents to attend with their children, as well as to liaise with other professionals.

Weekly baby clinics were held on Wednesdays and six week baby checks were also offered as part of monitoring children's health needs. There were emergency processes in place for referring children and pregnant women who had a sudden deterioration in their health. Appointments were available outside of school hours and same day appointments were prioritised for children and babies.

Mothers and young people had access to a wide range of contraception services including intrauterine devices, condom provision and emergency contraception.

Teenagers also had access to vaccinations such as tetanus; and a practice protocol was in place for identifying and supporting young carers. We found lifestyle advice, counselling services and health checks such as cervical and chlamydia were offered. Preconception care was also provided to women including those with epilepsy. Families and young people could also access support from the citizens' advice bureau at the surgery.

Working age people (including those recently retired and students)

Good

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

The practice had adjusted the services it offered to ensure they were accessible, flexible and offered continuity of care for patients. This included advertising its services via the social media for example twitter and facebook; and this was a preferred option for patients who could not visit the practice in person.

We found the practice had an awareness of the challenges the appointment system presented for working age patients and

Summary of findings

worked towards improving access for these patients. For example, patients had access to telephone consultations, an on call system, and pre-bookable appointments could be made a month in advance.

Online services were also available for patients to book their appointments and make prescription requests. Extended hours for both nurse and GP appointments were offered on Tuesday mornings and Wednesday evenings.

The practice was proactive in offering a full range of health promotion and screening services to improve the health outcomes of patients. This included cardiovascular health checks, travel vaccinations, contraception and smoking cessation. Clinical staff told us these health check appointments promoted early diagnosis of some long term health conditions and empowered patients to take better care of their health.

The practice website also contained useful information patients could refer to including minor illness and advice services to avoid the need to attend the practice if this were not needed.

People whose circumstances may make them vulnerable

Good

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

Patients falling within this population group mainly related to people with learning disabilities, people registering as temporary patients and victims of domestic violence or abuse.

We found the practice had close working relationships with other health and social care professionals to ensure the effective case management of people's care. This included participating in weekly multi-disciplinary team meetings to review care plans and the follow-up of referrals not attended. Staff knew how to recognise signs of abuse in vulnerable adults and children.

Staff were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. Information on local services relating to alcohol, drug and sexual health clinics were also available for patients to access.

The practice held a register of patients with learning disabilities. We found some of the patients had received their annual health checks and some had been planned up to March 2015.

Summary of findings

The practice had robust recall systems in place to ensure patients attended their appointments and annual health checks. This included undertaking a monthly report to identify patients due for reviews and making contact with them to attend.

We saw examples of where the practice liaised with the community support worker for patients with learning disabilities to encourage appointment attendance. Letters of invitation and care plans were written in an easy read format to ensure patients could understand.

The practice offered 40 minute appointments for the annual health review, this included 20 minutes with the nurse and 20 minutes with the GP. This also enabled sufficient time for the patients to be involved in decisions about their care.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health.

The practice facilitated weekly multi-disciplinary team meetings and staff worked closely with the community mental health teams. Meeting discussions included reviewing and monitoring the mental well-being of patients.

The practice kept a register of patients with mental health needs. Effective systems were in place to monitor that all patients were invited and received an annual physical health check, including cardiovascular functioning.

Patients on medicines such as lithium and requiring blood and electrocardiogram (ECG) monitoring had regular reviews of their treatment to ensure their safety. Lithium is commonly used to treat manic depressive disorder; and ECG is used to detect abnormal heart rhythms and to investigate the cause of chest pains.

The practice had a system in place to follow up on patients who had attended A&E where there may have been mental health needs.

We were shown an example of a care plan for a patient with a primary diagnosis of schizophrenia. The care plan included the patient's medicines, outcome of health reviews, arrangements for crisis management undertaken and support they received within the community.

The practice offered a directly enhanced service for dementia and this included memory testing for patients at risk of cognitive impairment. The practice also undertook extensive care planning and annual reviews for patients with dementia.

Summary of findings

Staff told us they encouraged patients to attend appointments by offering: longer appointments if needed; text reminders of appointments; same day appointments and where appropriate home visits and telephone consultations.

Clinical staff we spoke with told us they referred patients experiencing poor mental health to various support groups with their consent; of which we saw written literature in the waiting area. This included Talking Mental Health Derbyshire (an organisation that offers a range of therapies for people experiencing common psychological difficulties, such as those feeling anxious, low, or depressed).

Summary of findings

What people who use the service say

During our inspection we spoke with seven patients including two representatives of the Practice Reference Group (PRG). A PRG is made up of practice patients and staff and aims to ensure that patients are involved in decisions about the quality of services provided by the practice. All the patients we spoke with were complimentary about the clinical care they had received.

They told us they were involved in decisions about their care needs and were listened to on most occasions. They also expressed satisfaction with the accessibility of the practice, with most patients being able to access same day appointments. Patients told us suitable arrangements were in place to ensure they received their repeat prescriptions and medicines on time.

A member of the Patient Representative Group and also a carer to their husband told us of the good care they had received since accessing the surgery for the past 15 years during the practice's presentation to the inspection team.

We also received comment cards from three patients and three comments made via Healthwatch. Healthwatch England has significant statutory powers to ensure the voice of the patients is strengthened and heard by those who commission, deliver and regulate health and care services. Most of the comments were positive about staff competence, the quality of care received and the appointment system. Representatives of the PRG told us the leadership acted upon their views and feedback to improve the services offered to patients.

We reviewed the most recent national GP survey published in July 2014 and found 132 patients had responded. The results showed most patients were satisfied with the services provided by the practice. For example 97% of respondents found it easy to get through to this surgery by phone, and this was 23% above the regional average of 74%. In addition, 95% of respondents would recommend their surgery to someone new to the area and had confidence and trust in the last GP they saw or spoke to. These percentages were also above the CCG regional average and reflected positive patient experience.

The practice may wish to note that 64% of respondents stated they usually get to see or speak to their preferred GP. This was also reflected in patient feedback we received where a few people felt improvements could be made to ensure continuity of care.

Outstanding practice

- High patient satisfaction levels in relation to phone access, opening hours and a good overall experience of making an appointment. The 2013/14 Public Health England and the national patient surveys showed the practice values were above the regional and national average.
- The practice's involvement with community hospitals allowed the clinicians to provide care throughout the 'patient journey' and when their health needs increased. For example, patients receiving end of life care, management of acute illness and rehabilitation following a hip replacement. This was valued by patients and their carers as it allowed care to be provided close to home, and an admission to the acute trust hospital was avoided.

Darley Dale Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included a GP, CQC inspector and a CQC senior business officer.

Background to Darley Dale Medical Centre

Darley Dale Medical Centre provides primary medical services to 7 527 patients in the Darley Dale, Winster and Youlgreave areas of Derbyshire. The practice has two branch surgeries in Winster and Youlgreave, and they are both dispensing practices in rural settings. The practice has a population of 91% English speaking patients and translation services are available for patients whose first language is not English.

Darley Dale Medical Centre is also a GP training practice and provides training to GP registrars and F2 doctors. A GP registrar is a fully qualified doctor who has chosen to specialise in general practice and a F2 doctor is also fully qualified but yet to specialise. At the time of our inspection there was one GP registrar in training.

The practice clinical team comprises of four GP partners and three salaried GPs. Five of the GPs are females and two are male. The total number of GP and nurse sessions per week across all sites is 39 and 50 respectively; this excludes GP trainee sessions.

The nursing team comprised of one advanced nurse practitioner, five practice nurses, three healthcare assistants and one phlebotomist; all of whom were females.

The administration team comprises of a practice manager, assistant practice manager, three surgery managers, two in-house trainers, dispensers and administrative staff.

The practice holds a general medical service (GMS) contract to deliver essential primary care services, and a personal medical service (PMS) contract to provide personal medical services. Enhanced services offered include extended hours access, learning disabilities health check scheme and patient participation.

The practice is also commissioned to provide care to three local care homes and inpatient services at St Oswald's hospital in Ashbourne and Whitworth community hospital. Derbyshire Health United (DHU) provides out of hours services for registered patients with the practice.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the Clinical Commissioning Group, NHS England and Healthwatch to share what they knew. We carried out an announced visit on 8 October 2014. During our visit we spoke with a range of staff (GPs, practice nurse, practice management team, health care assistant and reception staff) and seven patients who used the service.

We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients shared their views and experiences of the service. We also spoke with representatives from care homes receiving weekly support from the practice.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, near misses, accidents as well as comments and complaints received from patients. We reviewed safety records, incident reports and meeting minutes where these were discussed this year. This showed the practice had analysed the information and implemented robust systems to reduce the risk of the events re-occurring and / or emerging themes.

For example, the practice policies and procedures were updated to minimise errors related to the administration of prescriptions, immunisations, patient information and diagnosis of patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Learning and improvement from safety incidents

We reviewed significant events that had been reported within the practice in the last 12 months. We found each significant event had been identified, reported and analysed in line with the practice's significant events policy and in a timely manner. Records showed investigation findings were discussed and learning was cascaded to all staff during practice meetings as well as monthly training sessions. The practice had a significant events policy in place and this had been shared with staff to inform their practice.

We saw that safety incidents also triggered a clinical audit being completed by a GP, to ensure the safety of other patients. For example, an audit of intrauterine contraception devices / insertions was undertaken following a significant event linked to a female patient not having attended their initial check-up after their coil implant was fitted.

A resulting action from this audit included amending the practice's consent form to include advice for patients to attend their coil check appointment within three and six weeks after it had been fitted. A repeated cycle had been planned for July 2015 to ensure improvements had been made.

The practice staff demonstrated accountability for errors made by informing the patient by way of a verbal and or apology letter for example, and taking appropriate action taken to address the error. This included a review of the patients' health needs and medicines where appropriate.

Clinicians we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They confirmed significant events were discussed at clinical meetings including guidelines informing best practice; and records we looked at confirmed this.

Staff we spoke with told us an open and transparent culture was promoted within the practice to ensure improvement and embedding of good practice. The management team told us all staff members were encouraged to report not only significant events but near misses and shared learning was documented.

Reliable safety systems and processes including safeguarding

Together with the lead GP for safeguarding children and vulnerable adults, we reviewed the practice's safety systems and processes. We found a system was in place for highlighting vulnerable patients on the practice's electronic records. This ensured the GP and / or nurse were aware of any relevant issues when patients attended appointments.

For example, information relating to case conference meeting minutes related to children at risk, victims of domestic abuse and children who failed to attend immunisation appointments. Meeting minutes showed a multi-disciplinary approach was taken in liaison with other professionals to review the risks to patients and agree protection plans. This ensured vulnerable patients received safe care.

The practice had up to date policies relating to safeguarding children and vulnerable adults. This also included the domestic abuse referral guide, Derby City and Derbyshire multi-agency safeguarding and risk management protocols. Staff we spoke with were aware of these policies and records reviewed showed all staff had read them. This also ensured consistency in how staff reported and dealt with suspected abuse. Staff were aware of the safeguarding GP lead and felt they were well supported with training, and received regular updates related to safeguarding; and this was reflected in records we reviewed.

Good

Are services safe?

For example, staff had received safeguarding training that was relevant to their role and knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding documentation of safeguarding concerns, liaison with the lead GP and referrals to other agencies.

A chaperone policy was in place and there were staff signatures confirming they had read it. The policy was also visible on the waiting room noticeboard, consulting rooms and practice website; and some of the patients we spoke with were aware it. Chaperone training had been undertaken by all nursing staff, and staff we spoke with understood their responsibilities.

Medicines Management

The practice had a lead GP for repeat prescribing of medicines and they were a member of the joint area prescribing committee in Derbyshire. Staff told us the GP took a proactive approach in reviewing the prescribing policies and ensuring they were up to date with recommended practice. This was reflected in the clinical audits and clinical meeting minutes we reviewed.

A repeat prescription policy was in place and this defined the roles for both clinical and non-clinical reception staff. For example, specific instructions were detailed for reception staff of when not to print prescriptions but to assign the task to the GP; and only GPs could initiate medicine prescriptions or amend patient medicine records. Prescriptions were reviewed and signed by a GP before they were given to the patient to ensure they were still appropriate and necessary.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme. This scheme rewards practices for providing high quality services to patients of their dispensary. We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

Patients could pick up their dispensed prescriptions at Darley Dale surgery and systems were in place to monitor how these medicines were collected. The practice had undertaken a dispensing services quality audit for all three surgeries. This audit included seeking patient feedback in relation to ease of ordering medicines, timing / collection, advice quality and staff courtesy. The patient results showed all the respondents rated these areas as excellent and staff were applauded for their work by the team.

The practice was quick to implement changes in response to new guidelines relating to specific medicines. For example, in May 2014 the Medicines and Healthcare Products Regulatory Agency (MHRA) issued the advice that domperidone use was now restricted to relief of nausea and vomiting, and should be used at the lowest effective dose for the shortest duration of time.

The advice was following evidence that use of domperidone was associated with an increased risk of serious cardiac side effects. To ensure patient safety, the practice undertook the following steps: guidance was discussed at the clinical meeting to ensure awareness of the new prescribing recommendations; an alert was added to the patient record to prompt clinicians to assess indication for use and consider cessation or dose change; and a full clinical audit was undertaken in May and September 2014.

The outcome of the audit showed all but one patient was able to be discontinued from this medication, and identified risks to the one patient were discussed with them and recorded in their patient notes. In addition, we reviewed significant events related to medicines and found these were investigated appropriately and learning was discussed and documented for staff to refer to.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Records reviewed showed nurses had received appropriate training to administer vaccines. Processes were in place to check vaccines were kept at the required temperatures and within their expiry date. All the medicines we checked were within their expiry dates, stored securely and were only accessible to authorised staff.

The practice had also checked that 100% of fridge items were held and dispensed safely in accordance with the practice dispensary statement of purpose (SOP) at all the three surgeries. The initial audit findings showed all dispensers were fully compliant with the SOP, and the reaudit identified training needs for staff in relation to fridge item handling. Arrangements had been made for staff to receive the related training.

Good

Are services safe?

Cleanliness & Infection Control

The practice had effective systems in place to reduce the risk and spread of infection. This included obtaining patient feedback on the standards of hygiene within the practice, audits of infection control practices as well as training and guidance for staff. Patients we spoke with told us the practice was clean when they visited and they had no concerns with staff attitudes to hygiene.

This positive feedback was also reflected in the 2014 practice patient survey. The results showed 233 out of 234 respondents felt the reception and clinical rooms were very/fairly clean, and most patients had seen their GP or nurse washing their hands after or before an examination.

We found the practice to be visibly clean and tidy; with some areas requiring redecoration. Daily cleaning schedules were in place and the respective tasks were completed and recorded by the domestic staff employed by the practice. There were adequate provisions of cleaning materials, hand hygiene facilities such as hand washing sinks, hand soap/gel and disposable hand towels.

The practice also undertook an annual infection control audit to assess and manage risks to the health and welfare of patients. For example, we saw evidence of action plans being developed and implemented to address areas of concern. However, we found some flat top bins for clinical and non-clinical waste had not been replaced with pedal operated bins as identified in the November 2013 audit for example. The practice told us this would be addressed after our inspection and we could not verify this in person.

Practice meeting minutes reviewed showed the findings of the audits were discussed with staff to promote learning. There were contracts in place for the disposal of clinical waste, and we saw that waste, sharps and used syringes were appropriately segregated and stored. Spillage kits were also kept in the treatment rooms for use when required.

The practice had a GP lead for infection control and they provided guidance on the practice policies and staff training for example. There were up to date policies related to infection control, management of sharps injuries and decontamination of equipment. These policies set out the responsibilities for staff and the practice maintained a record to confirm they had been shared and read by staff.

Training records reviewed showed staff had received infection control training including hospital and community acquired infections; and staff were able to give examples of how they complied with the practice's policies. This included use of single use items of equipment per patient and personal protective equipment such as disposable gloves and aprons.

Equipment

The practice periodically tested and maintained its equipment to ensure it was safe for use. For example, portable electrical equipment was tested at least annually and stickers were displayed indicating the last testing date. We saw evidence of calibration of medical equipment for example blood pressure monitors and vaccine fridges. Staff we spoke with told us they had sufficient equipment to perform their role.

Staffing & Recruitment

Patients we spoke with told us they felt safe using the service and had confidence in the staff. This was supported by the July 2014 GP patient results which showed 95% of respondents had confidence and trust in the last GP they saw or spoke to; and 93% had confidence and trust in the last nurse they saw or spoke to.

The practice had clear procedures in place to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff. Examples included investing in a high ratio of clinicians to registered patients which facilitated person centred care; and GPs having various specific areas of clinical expertise and experience.

The practice had carried out a needs analysis as basis for deciding sufficient staffing levels for the three surgeries. This included arrangements to cover absences and emergencies, as well as supervision of new staff and GPs in training.

A rota system was in place for all the different staffing groups to ensure there was enough clinical and non-clinical staff on duty. Staff we spoke with told us whilst they were often very busy, they felt there were enough staff to meet patients' needs and maintain the smooth running of the practice.

The practice had a recruitment policy in place that set out the standards it followed when recruiting permanent and locum staff. Staff files we looked at showed appropriate recruitment checks had been undertaken prior to

employment. For example, staff had been interviewed for the posts they had applied for and were offered a contract of employment subject to satisfactory pre-employment checks.

These checks included: proof of identity and a photograph, written references, pre-health questionnaire and verified copies of educational and training certificates. The practice ensured a satisfactory criminal record check was received for all staff with unsupervised access to vulnerable adults and children before they were employed.

Professional registrations for GPs and nurses were also checked to ensure they were allowed to work by the General Medical Council and Nursing and Midwifery Council. Newly appointed staff were supervised during their induction and a locum induction information pack was provided to them. We found these checks ensured patient care needs were met by staff that were fit, appropriately qualified and physically able to do their job.

Monitoring Safety & Responding to Risk

The practice had robust systems in place to assess, manage and monitor risks to patients, staff and visitors safety. For example, staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. This included use of monitoring systems related to: the repeat prescribing for patients receiving medication for mental health needs; and people with long terms conditions who had not attended for treatment or medication reviews. The needs of patients receiving palliative care were also discussed at multi-disciplinary meetings including supporting them to access emergency care and treatment.

The practice also undertook safety checks related to the premise and the environment; and a health and safety policy was in place. We saw that risks were discussed at the practice meetings and patients were being consulted on the future of the practice building.

Arrangements to deal with emergencies and major incidents

The practice had procedures in place to deal with emergencies and this included a disaster handling and business continuity plan. The plan included mitigating actions to manage risks relating to information technology, staffing changes, adverse weather, and the premise for example. The document also contained relevant contact details for staff to refer to.

We found staff had received training in basic life support and / or cardio pulmonary resuscitation (CPR); and further training for business continuity and fire safety had been arranged for November 2014. Staff we spoke with felt confident to take appropriate action in a medical emergency and knew the location of emergency equipment.

Emergency equipment available included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). These were checked to ensure they were suitable for use. We found emergency medicines were also checked to ensure they were within their expiry dates and all the medicines we checked were in date.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance including guidelines from the National Institute for Health and Care Excellence and North East Derbyshire CCG. Meeting minutes reviewed showed new guidelines were disseminated amongst staff. This informed decision making about the implications for future planning and delivery of patient care.

Care plans and discussions with GPs and nurses showed staff completed thorough assessments of patients' needs. The practice also placed emphasis on a holistic approach to patient care and this was evidenced in the care plans we reviewed. Clinical staff we spoke with were told us they were very open about asking for and providing colleagues with advice and support.

One of the GP partners had designed an in-house Quality Outcomes Framework (QOF) patient data recording template for the clinical system and this was now being used by other practices. QOF is an annual reward and incentive programme showing GP practice achievement results.

Records reviewed showed the practice provided care throughout the 'patient journey'. The practice's role at the community hospital (Whitworth) allowed the clinicians to continue patient care when their needs increased. For example, patients receiving end of life care, management of acute illness and rehabilitation following a hip replacement.

One of the GP partners told us this was valued by patients and their carers as it allowed care to be provided close to home and an admission to the acute trust hospital was avoided. We were invited to attend a multi-disciplinary meeting on the day of our inspection and we found the practice continued to liaise with hospital teams and hospital 'flow' nurse if patients were admitted.

The practice had effective prescribing arrangements in place and had achieved its set targets under the Dispensing Services Quality Scheme. The practice consistently underspent the Clinical Commissioning Group (CCG) and national prescribing budget, whilst ensuring patients received the medicines they required. Data for October to December 2013 showed the practice had achieved 16% costs lower than PCT and national equivalent. The North Derbyshire CCG data showed the practice consistently maintained high standards in quality prescribing indicators.

One of the GP partners was a member of the joint area prescribing committee and was actively involved in prescribing policies. Records showed practice staff were kept up to date on prescribing matters at clinical meetings.

Management, monitoring and improving outcomes for people

An area of very good practice we noted related to the quantity and quality of clinical audits used to assess and monitor the quality of service provision. We found the clinical audits had clearly defined criterion and summarised the action taken by the practice in the light of the audit findings.

For example, the practice had audited the influenza and pneumococcal vaccine uptake in patients with heart failure. The findings showed 82% patients with heart failure had flu vaccine and 77% patients with heart failure had pneumococcal vaccine. In response to this, the practice had increased its in house promotion of vaccines and an alert was placed on records of patients with heart failure requiring this vaccine to prompt the clinician to act on this. Plans to re-audit these measures were scheduled for January 2015.

The practice showed us 18 clinical audits that had been undertaken in the last 12 months. Seven of these were completed audits where the practice was able to demonstrate the resulting changes since the initial audit was completed.

We found other examples of clinical audits were linked to medicines management information, safety alerts and information from the quality and outcomes framework (QOF). QOF is an annual reward and incentive programme showing GP practice achievement results. For example we saw an audit regarding the prescribing of terbinafine for fungal infections and adrenaline injections for anaphylaxis. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice in line with the guidelines.

Good

Are services effective?

(for example, treatment is effective)

GPs maintained records showing how they had evaluated the service and documented the success of any changes. GPs that we spoke with commented positively about the culture in the practice around clinical audit and quality improvement.

The practice also undertook weekly review of patient information relating to hospital admissions and discharge summaries. Changes to the care and treatment of patients resulted in their respective care plans being updated. Meeting minutes that we looked at showed the practice participated in internal and external peer group meetings where clinical issues were discussed and used to drive improvements to patient care.

The practice had a clinical lead and clinical meetings were held to reflect upon the outcomes achieved and areas where this could be improved. The practice clinical lead was also the chair and clinical lead to the North East Derbyshire CCG.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had comparable and higher outcomes to other practices in the CCG area. For example, information shared by NHS England in September 2014, showed the practice value for depression assessments, severe mental illness physical health checks, dementia diagnosis rate, recording smoking status and smoking cessation advice were higher than the CCG and England values.

The practice used 'risk stratification' to identify patients at risk of re-hospitalisation and risk management plans were drawn up for those patients. A monitoring board was also used to record patients admitted in hospital to enable the GPs to follow-up on discharge arrangements.

The practice had suitable arrangements in place to liaise with the out of hours service in relation to patients presenting with emergency needs. All incoming clinical correspondence and pathology results were screened, coded and actioned by the GPs. Blood tests and / or imaging results were also checked to ensure they had been received. The practice had also been proactive in liaising with the local hospital when the hospital had failed to inform them of some blood results.

Effective staffing

We found patients' health and care needs were met by competent staff and the practice had an established staff team. The practice had a high ratio of clinicians to registered patients. This enabled clinicians to focus on patient care and ensure continuity of services. The professional development of staff was through a regular system of appraisal, team meetings and one to one session.

Two new staff we spoke with told us they had received an induction to ensure they were aware of the practice systems and culture. We spoke with one GP registrar and they told us they were well supported during their training. This included access to a senior GP and practice guidelines, as well as extended appointments to see patients (15-20 minutes).

GPs that we spoke with told us they were up to date with their professional development requirements, and had either been revalidated or had a date for revalidation. (Revalidation is the process by which GPs are required to demonstrate on a regular basis, that they are up to date with current best practice and remain fit to practice).

The advanced nurse practitioner and practice nurses had defined duties they were expected to perform; and records reviewed showed they had appropriate training to fulfil these roles. For example, staff had received training in administration of vaccines, insulin management, end of life care and wound care. Records also showed that non-clinical staff had received mandatory training related to their specific roles. Staff told us they felt well supported and could access additional training when required.

Working with colleagues and other services

The practice worked with other providers to meet patients' needs and manage complex cases. This included obtaining appropriate health and social care support for patients and care planning arrangements that met their individual needs. For example, the practice held regular multidisciplinary team meetings to discuss the needs of people receiving end of life care, people with long terms conditions, families and children on the risk register. These meetings were attended by social workers and school community nurses for example.

Safeguarding meeting minutes showed additional support and / or referrals was provided to the families and children. This included a review of the parent's mental wellbeing,

Good

Are services effective?

(for example, treatment is effective)

signs of depression and checks to ensure the baby was developing well. Staff felt this promoted integrated care and was a useful means of sharing important patient information.

The practice had strong working relationships and collaboration arrangements with the community teams. For example, district nurses visited daily to each surgery site and their base was located within Darley Dale surgery. The GPs made frequent referrals to the integrated care team based locally at Bakewell and had strong links with social care, physiotherapists, podiatry and occupational therapists (all located locally at Community Hospital Whitworth).

Information Sharing

The practice had an information governance policy in place and this had been shared and discussed with staff. Staff that we spoke with showed awareness of the need to keep patient information confidential and medical records securely stored. The practice used a range of electronic systems to communicate with other providers and had procedures for secure information sharing. Some of the systems used included choose and book, summary care records and system one. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

The practice had signed up to the electronic summary care record and this was being used at the time of our inspection. Summary care records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. The practice also used an electronic patient record (SystmOne) to coordinate, document and manage patients' care. All staff were fully trained on the system, and this software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice had effective procedures in place for sharing appropriate information relating to hospital admission and discharge, as well as the coordination of emergency procedures. For example, blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received electronically and / or by post.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Consent to care and treatment

Patients we spoke with told us they were involved in decisions about their treatment, and confirmed consent had obtained before the delivery of their care. We found staff had received training related to the Mental Capacity Act 2005 and were aware of their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they supported patients to make their own decisions.

A patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure; and signed consent forms were scanned onto their patient notes. Patients were asked for their consent for procedures such as insertion of intrauterine devices, sharing of summary care record and do not attempt resuscitation decisions. Staff could access the practice consent policy to support their decision making when gaining patient's consent to treatment and examination.

Patients with learning disabilities and those with dementia were supported to make best interest decisions through the use of mental capacity assessments and / or care plans which they were involved in agreeing. The care plans had a section stating the patient's preferences for treatment and decisions; and were reviewed at least every three months.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

All new patients were offered an initial consultation to review their social and lifestyle histories. This informed the provision of health promotion advice and their management plan. The management plan included referral to health trainer, dietician or community alcohol team. The GP was informed of all health concerns detected and these were followed-up in a timely manner.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a range of health promotion services for adults and written information was available to support people live healthier lives. This included NHS Health checks to all its patients aged 40-75, smoking cessation schemes and cervical screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013/2014 performance for 24 month old children immunisations was above average for the CCG, and slightly below for 12 months and five years. The practice had effective systems in place to recall patients who did not attend their screening appointments and / or immunisation appointments.

The practice kept a register of all patients with learning disabilities and mental health needs, and they were offered an annual physical health check. Patients who required on-going monitoring of their long term conditions such as chronic obstructive pulmonary disease (COPD), heart disease, and asthma were subject to recall appointments to ensure they were followed up in a timely period. These patients were offered further support in line with their individual needs.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All the patients we spoke with told us staff treated them respectfully and worked to ensure their privacy and dignity was maintained. This included being offered a chaperone and curtains being drawn when having an examination, and doors being closed during a consultation. We noted the practice's chaperone policy was also displayed in the reception/waiting area and practice booklet. Patients described staff as being caring, friendly and happy to help.

This positive feedback was also reflected in the national patient survey, Public Health England data and satisfaction questionnaires undertaken by each of the practice's GPs. For example, data from the 2013 national patient survey showed the practice was above the national average for its satisfaction scores on consultations with GPs and nurses.

For example 96.9% of practice respondents stated the nurse was good or very good at treating them with care and concern; and this was 6.4% above the national average. 96.8% of respondents described the overall experience of their GP surgery as fairly good or very good and this was above the 85.8% national average.

Records we reviewed showed staff had received training related to patient dignity and chaperone duties; and their appraisal included discussion on dignity and respect. Staff we spoke with gave examples of where they felt they went the "extra mile" to ensure patients received a caring service. For example, frequent calls made on behalf of patients to chase up hospital appointments, medication queries and investigation results; as well as contacting patients known to be vulnerable or have dementia to remind them of their appointments.

The practice was also awarded the Derbyshire Dignity Award in 2013. This was a result of an assessment process where the practice was able to demonstrate how dignity and respect, was placed at the heart of services patients received. We reviewed this evidence and spoke with some staff about their experience of participating in the Dignity in Care Campaign.

Staff feedback showed they promoted patients privacy and dignity by placing their needs / preferences at the centre of assessment, planning and delivery of care. For example: all consultations and treatments were carried out in the privacy of a consulting room; and a room was made available for patients who preferred not to discuss their health needs in the reception area.

We observed staff were careful to follow the practice's confidentiality policy when discussing patient information to ensure it was kept private. The provider may wish to note that a few patients we spoke with felt patient information was not always kept private due to the layout and restricted size of the reception / waiting area. This was also supported by the GP patient survey results which showed 59% were satisfied with the level of privacy when speaking to receptionists at the surgery. The practice was aware of this feedback and had already identified the need for new and larger premises in consultation with patients and NHS England.

Care planning and involvement in decisions about care and treatment

Six out of seven patients we spoke with told us staff listened to their health needs and sufficiently involved them in making decisions about their care. One patient told us their implant procedure was fully explained to them and appropriate information was provided to ensure they could make an informed decision about their care.

Patient feedback from comment cards we received and the national patient survey were also positive and aligned with these views. For example, GP patient survey results published on 03 July 2014 showed 132 respondents felt involved in decisions about their care. For example: 93% patients said the last GP they saw or spoke to was good at giving them enough time; 94% said the last GP they saw or spoke to was good at listening to them and 91% say the last GP they saw or spoke to was good at explaining tests and treatments.

The clinicians we spoke with demonstrated an awareness of patient involvement, seeking an individual's preferences before treatment was delivered, and acting upon the decision. For example, one GP told us their routine practice included explaining the benefits and risks involved of proposed treatments; as well as obtaining valid consent (verbally and / or in writing where appropriate) before they provided care.

The practice had robust systems in place to assess and review care plans for patients with the following care needs: dementia, long term conditions, severe mental

health, palliative care, nursing home patients and patients at risk of hospital admission. We were shown examples of care plans relating to some of these population groups to evidence the work undertaken and patient involvement in agreeing to them.

The practice also made provisions for double / longer appointments when reviewing care plans to ensure sufficient time during consultations. Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception area informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The practice used a "Kid Glove Board" to record patients needing additional care and support due to their health needs and social circumstances. This included patients receiving end of life care, or discharged from hospital, as well as older people at risk of isolation and elderly carers. Staff we spoke with told us this was discussed as a team and enabled them to be sensitive when they spoke to the patients, booked an appointment for them and / or signposted them to support groups.

The practice had a system in place where bereavement visits were routinely offered to a carer and / or family member of a deceased patient. This was triggered when the practice received a death notification relating to any of their registered patients. We saw three complimentary cards from family members praising staff for their support during the illness of their loved ones. The feedback showed the staff responded with compassion, maintained regular contact and liaised with other care providers to ensure integrated care, and provided adequate care.

Patients were also signposted to a number of support groups and organisations, and relevant information was displayed in the reception / waiting room areas and the practice website.

The practice's computer system alerted GPs if a patient was a carer and appropriate referrals were made to Derbyshire Carers Association for example. We were shown the written information available for carers including young carers, to ensure they understood the various avenues of support available to them. This information was also available on the practice website under the "carers' direct" section.

Additional services offered to patients included: pre-conceptual care for women, referrals for counselling and support groups related to drug and alcohol use. Clinical meeting minutes and care plans reviewed showed extra support was provided to families in disadvantaged circumstances and specific populations groups through multi-agency working. This included close working arrangements with district nurses in relation to patients with palliative care needs and dementia, as well as referral to social services for social care assessments.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patient feedback and comment cards reviewed showed the service was responsive to patient needs on most occasions. We found the practice carried out extensive care planning work to meet the needs of different population groups. For example, patients with dementia, long term conditions, severe mental illness, palliative care, nursing home residents and patients at risk of hospital admission. The care plans that we looked at showed patients' needs were assessed, and that care and treatment was planned and delivered to meet their needs.

The practice maintained close working relationships with other health and social care professionals to ensure that appropriate care planning took place. This included weekly multi-disciplinary team meetings and regular discussions with the district nurses, care coordinator and the community matron. Staff we spoke with felt this was a very effective forum to coordinate patients care and communicate any changes to patients' treatment.

We were invited to attend a multidisciplinary team meeting on the day of our inspection. Our observations were that the practice took a wide interpretation of "vulnerable adult" and engaged in excellent integrated care for the elderly and patients with complex care needs. This included patients' wishes being taken into account in planning their end of life care, in-depth discussions amongst health and social care professionals and plans being made to engage with secondary care and the patient's carers. This ensured patients' care and treatment were monitored and adjusted to reflect changes in need.

The practice was actively engaged with NHS Local Area Team (LAT), North East Derbyshire Clinical Commissioning Group (CCG) and nine other GP practices within the North Dales locality; to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements.

For example, care co-ordinators with the responsibility of coordinating the care plan for patients with more complex needs were in post; and locality wide discussions had taken place about how partners can work together more efficiently, to avoid unnecessary hospital admissions by ensuring good services in the community.

The practice offered a range of in-house services and clinics for each population group we inspected. For example, older patients were offered memory testing, flu vaccines and access to the district nurse or community matron. Mothers were offered a full range of contraceptive services, baby developmental checks and immunisations were also offered to children.

Health checks such as cervical screening and prostate cancer monitoring were available to females and male respectively. Annual reviews including medicines were also undertaken for patients with long term conditions, learning disabilities and mental health needs. A self-monitoring blood pressure machine was available for patients to use without an appointment therefore offering flexibility to patients. A robust system was in place to record these blood pressure readings and ensure they were acted upon by a clinician. The practice also offered blood and drug monitoring services including phlebotomy and electrocardiogram (ECG).

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Representation Group (PRG). These included improvement to the practice website and promotion of social media to engage patients preferring online services. The PRG is made up of patients and staff, and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice.

Tackle inequity and promote equality

The practice understood the different needs of the population it served and acted on these to design services. We found the planning and provision of services was influenced by some of the following factors: patient health needs and / or disabilities; age; sex; faith; social life and communication needs. For example, the practice website included a translation facility for 20 different languages to enable patients to access the information; and staff had access to interpreting services when a patient did not speak English as a first language.

A hearing loop system was in place for patients experiencing hearing difficulties, and the premises had been adapted to meet the needs of people with physical disabilities. This included easy access for wheelchair users. Staff told us patients with visual impairments were informed when the GP / nurse was ready to see them and were escorted to the consultation room.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The new patient registration form prompted patients to consider and record the assistance they required during consultations, for example a sign language translator. This information was then recorded on the patient's records so that appropriate action was taken when booking appointments or arranging care.

A flagging system on patient's electronic care records was also used to alert the staff about patients' vulnerability, faith and advance decisions about their health care needs. This enabled the clinicians to take account of these needs when providing care and treatment.

The practice had an equality and diversity policy in place. The policy detailed procedures for ensuring each patient was given equal opportunities to access the service and receive good care. We saw that the policy had been shared with staff and staff had received training in March 2014. The training included key areas such as promoting an inclusion culture, equal access to opportunity, respecting and valuing people's differences.

Staff we spoke with confirmed equality and diversity was regularly discussed at team events and / or supervision sessions' and minutes we looked at confirmed this. An equality statement accessible to patients was also available; and this stated the practice's commitment to 'treating people fairly, with respect and dignity and as individuals'.

The practice acknowledged under-representation of young people and those under 35 within the patient reference group (PRG). The practice continued to promote the group via health visitors, nursing staff and the use of social media to address this issue.

Access to the service

Patient feedback and the information we reviewed showed a high satisfaction rate with the appointment system at all three surgeries. All the patients we spoke with reported no difficulties making an appointment and described the system as really good. They told us they were able to get same day appointments, choose a preferred GP, date and time for routine appointments and did not have to wait too long for their allocated appointed time.

One patient told us they had sustained an accident whilst on holiday and were able to see a GP on the same day of contacting the practice. Two out of six written comments received suggested improvements were still required to ensure availability of appointments with the same GP and access for working age people. We found the practice was working towards improving these two areas; and this included promoting telephone consultations, same day appointments and the use of social media such as twitter and facebook.

Information taken from Public Health England for 2013/14 showed 96% of the respondents were satisfied with phone access, about 93% were satisfied with opening hours and about 91% reported a good overall experience of making an appointment. These percentages were amongst the best when compared against the practice average across England.

This feedback was also reflected in the GP patient survey results published on 03 July 2014. The results showed 97% of the 132 respondents found it easy to get through to this surgery by phone and this was above the CCG regional average of 74%. 92% of respondents also described their experience of making an appointment as good.

Healthwatch Derbyshire undertook an "enter and review visit" on 6 August 2014 and spoke with 20 patients, both male and female and varying in age. Their summary of findings included the following comments: "Patients said they were satisfied with the current appointment system but where patients found it difficult to get an appointment, staff tried their best to accommodate them"; and "the culture of the practice was that it tried to accommodate every patient no matter what the dilemma". The full report is available to read on the practice website.

The surgery manager for Darley Dale practice talked us through the appointment system. This included the following provisions: pre-bookable appointments could be made a month in advance; on call appointments were available after 10.30am and extra GP appointments were also available should there be additional demand on a given day. The first two appointments for the advanced practitioner were pre-bookable and the others were same day appointments.

Records reviewed showed fortnightly discussions were held between management and the three surgery managers to review the appointment system to ensure improved patient access. The practice was commissioned to provide a dedicated GP service to three local care homes and had contracts with Whitworth hospital (Community hospital in

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Darley Dale) and St Oswalds hospital (community hospital in Ashbourne). This included a weekly visit to the care homes and a ward round, ad hoc visits and / or telephone contacts to the hospital.

We found appointments could be made in person, online or via the telephone; and the opening hours were displayed in the practice and on the website. For example, Darley Dale Surgery offered extended hours on Tuesday and Wednesday (7:30 am to 8:30 am and 6:30pm and 8pm respectively) and staff told us this was popular for working age population. The surgery was open between 8am and 6.30pm on the other days. The practice also offered afternoon opening hours for the branch surgeries at Winster and Youlgreave surgeries; with afternoon sessions starting at 2pm and ending at 6pm twice weekly.

Comprehensive information on making appointments, requesting telephone consultations and home visits was also available to patients within the surgery, practice leaflet and website. This included contact details for NHS 111, ambulance services / 999 and Derbyshire County Primary Care Trust responsible for the out-of-hours service.

The practice offered services such as text message reminders for appointments and test results, and choose and book referrals. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

Prescriptions requests were made via telephone email, online, in person and a box in reception. Home visits were made available to patients who were housebound or too ill to visit the practice. All the GPs were able to provide telephone consultations and patients were able to leave telephone messages for clinicians to respond. There had been very little turnover of staff which enabled good continuity of care and accessibility to appointments with a GP of choice.

Listening and learning from concerns and complaints

The practice had a complaints policy in place and this helped staff and patients to understand the reporting procedures. We saw information relating to the complaints policy were displayed in the reception area and contained in the practice leaflet. All the patients we spoke with told us they had no complaints and were aware of the process to follow should they wish to make a complaint.

Staff we spoke with were aware of the complaints policy and were confident in describing the process. Records reviewed showed some staff had received training in patient experience and conflict resolution to support them in dealing with concerns and complaints.

The practice manager was the responsible person who handled all complaints in the practice and they kept a log of complaints received. Records showed the practice had received three complaints within the last twelve months. These had been discussed with staff to ensure they were all able to contribute to any improvement action that might be required.

We found lessons learnt from each complaint had been acted upon and used to make improvements to the service provision. For example, the practice manager and nurse manager met once a week to review nurse availability over a three month period following a complaint about nursing appointments.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to assess the health needs of patients and provide high quality care by maximising available resources. We found this vision was underpinned by five core values which included: quality; local provision; compassion and service; fiscal responsibility and innovation.

Staff we spoke with demonstrated awareness of the practice vision and values, and knew what their responsibilities were in relation to these. In particular, three staff members gave examples of how their day to day work translated the practice vision into a caring and learning environment. This included a patient centred focus when welcoming patients to the surgery and care planning; as well as the use of up to date clinical knowledge to improve patient outcomes.

The practice facilitated 'away half days' for the GP partners and practice managers, to enable them to focus on "where we are and where we are going". The outcomes from these meetings were then shared with the rest of the practice team to promote ownership and engagement; and records we looked at confirmed this.

Governance Arrangements

The practice had suitable arrangements in place to govern administrative and clinical activities. This included policies and procedures related to information governance, business continuity, and the dissemination of clinical guidance and medical alerts. Records reviewed showed all practice staff had access to policies and procedures relevant to their role; and this was confirmed by staff we spoke with. Staff told us there were clear about their own roles and responsibilities, and felt well supported.

We found robust clinical governance arrangements were in place and ensured safe and effective care for patients. For example, each of the GP partners took a lead role in specific areas of clinical practice and this included: significant events, decontamination, repeat prescribing and controlled drugs.

Meeting minutes reviewed showed these areas were regularly discussed and action plans were produced to maintain or improve patient outcomes. Where risks had been identified, risk management plans were in place and reviewed to ensure they remained appropriate.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is an annual reward and incentivised programme showing GP practice achievement results. The 2013 / 2014 QOF data showed the practice was amongst the best with an achievement of 99.6% out of 100% for its total QOF points. This was above the practice value of 96.4% across England.

The North Derbyshire Clinical Commissioning Group also described the practice as an achieving and high performing practice. The practice took part in a local peer review system with neighbouring GP practices to measure its service against others and identify areas for improvement.

The practice had an on-going programme of clinical audits which it used as a quality improvement process to improve patient care, and identify where action should be taken. We found the practice to be very good in the quality of its clinical audit work and implementing changes. This ensured best practice was followed by staff in the care and treatment of patients.

For example, clinical audit criterions were linked to Medicines and Healthcare Products Regulatory Agency (MHRA) advice, significant events, risks related to specific population groups, National Institute for Health and Care Excellence (NICE), and Derbyshire guidelines.

Records reviewed showed the outcomes of clinical audits were discussed with staff in practice meetings and / or Quality Education and Study Time (QUEST) sessions to agree changes. Re-audits were also undertaken to confirm improvement in the care provided to patients, embedding of agreed actions and updated procedures for use by staff.

Leadership, openness and transparency

A clear leadership structure with named members of staff in lead roles was in place and this ensured a team approach to managing the practice. For example, the non-clinical management team included the practice manager, assistant practice manager and three surgery managers.

Administrative staff we spoke with told us there was an open culture within the practice and they felt valued. The clinicians also felt they received excellent support from their managerial and administrative staff. Practice meetings involving all the staff were held at least monthly. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with the leadership.

Are services well-led?

Good

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

One of the GP partners and also the CQC Registered Manager told us the practice strived for continuous improvement to the services it provided. This included the leadership celebrating its achievements and exploring alternative solutions to address identified areas of improvement. For example, consideration was given for colleague recognition for outstanding work done at the monthly partners meeting. This included roles in influencing local services for patients, clinical expertise and feedback received from patients.

A strong emphasis on communication between partners was promoted with fortnightly meetings held to discuss current working and strategies for improvement.

The practice had identified areas of improvement and had plans in place to address them. For example, the leadership had developed a new role of a team manager responsible for the co-ordination of services between all three surgeries. This was in response to the need to maximise communication between staff and ensure continuity of care for patients. Interviews had been planned for week commencing 9 October 2014 after our inspection.

The practice had also submitted a business case to NHS England in June 2014 for a larger surgery in Darley Dale. This was to enable the practice to accommodate more staff and services; and cope with the increasing number of patients registering with the surgery. We noted from the practice website and Patient Representation Group meeting minutes that patients were involved in the consultation of the new premises.

Practice seeks and acts on feedback from users, public and staff

We found patient feedback was gathered through surveys, discussions in Patient Reference Group meetings (PRG), comment cards and complaints received; and this was acted upon. The PRG is made up of patients and staff, and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice. The PRG meet four times a year and is mainly represented by patients within the working age, recently retired and older people population groups.

The practice manager showed us the analysis of the most recent patient survey which was developed with the PRG. The results and actions agreed from these surveys were available on the practice website and in the surgery. For example, an identified area of improvement following the 2013/14 patient survey was to develop a social media profile to promote existing and new services.

We found this action including updating the practice website had been completed in July 2014. The practice had received 90 000 patient views on its website within three months of redevelopment, and the use of social media such as twitter and facebook had widened their patient audience.

We spoke with two members of the PRG and they gave positive comments about their partnership working with the practice team. They told us patients could make suggestions to the agenda items and these were included. They also felt they were kept up to date about service provision and NHS developments by the GP partner, who was also the North East Derbyshire CCG chair and clinical lead. The provider may wish to note that a few of the patients we spoke with were not aware of the PRG and how to become a member, although we noted there was information displayed about this group.

The practice gathered feedback from staff through staff meetings, away days, supervision, appraisals and informal discussions. Staff told us they felt involved in ensuring positive outcomes for patients and themselves. We noted high levels of staff satisfaction in relation to job satisfaction and support from management. For example, staff told us they felt very much part of team, were proud to work at the practice and it was a nice working environment. The practice had a whistle blowing policy in place and staff we spoke with were aware of it, but had not had cause to use it.

Management lead through learning & improvement

Another area of very good practice we found related to the way in which the management assessed and monitored the quality of its service provision; as well as shared innovative practices with other GP surgeries. For example, the practice had designed personalised QOF template forms to record vital patient information relating to specific health condition; following the practice's research on the 2013/14 Quality Outcomes Framework (QOF) requirements. This was shared with EMIS and SystmOne who are providers of general practice computer systems.

Are services well-led?

Good

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

The QOF forms included instructions and clinical guidelines for GPs and nurses to use when assessing the needs of patients with chronic diseases for example. We were told that Darley Dale Medical practice held events in Derbyshire for other practices to attend and provided free copies of these templates. Over 40 practices in Derbyshire are reported as using the templates forms from 01 April 2013, to help improve the quality of their QOF work.

The practice leadership felt this was an innovative solution to ensure clinicians had appropriate recording tools and best practice guidelines for assessing and monitoring patients' health needs. As a result of this work, Darley Dale Medical practice has consistently maintained high QOF scores in comparison to other local practices. Our inspection findings showed the practice was very good at recording what they need to meet QOF requirements as well as providing good patient care.

The GP partners also held external and strategic roles with other health agencies. This included advisory roles in the Derbyshire prescribing committee, Derbyshire GP federation, CQC GP Specialist advisor and the clinical lead / chair of North East Derbyshire CCG. Some GP partners also contributed to local and national written literature on improvement work and innovative practices related to patient care and health service provision. We found this was hugely beneficial to patient care in that a culture of continuous improvement and evidence based practice was promoted.

The practice completed regular reviews of significant events and near misses; and these were shared at staff meetings to ensure the practice improved outcomes for patients. For example processes and procedures relating to medicines management, prescription handling and management of staff rota had been updated as a result.

The practice was a GP training practice with two of the partners being GP trainers and two partners' appraisers. Staff we spoke with including a GP in training told us the leadership supported them to maintain their professional development through training and mentoring.

Records reviewed showed the leadership was also committed to developing a skilled workforce and placed emphasis on career progression for staff. For example, a receptionist recently trained as a phlebotomist (staff responsible for collecting blood samples from patients for examination in laboratories) and was now developing their role as health care assistant; and a receptionist was undergoing training for a dispensing role.

Another staff had joined the practice as an apprentice working on reception, was successful in gaining employment as a receptionist and later as a trainer. The staff member had also been nominated for an external award for her apprenticeship on social media and was due to attend the ceremony at the House of Lords.

We looked at three staff files and saw that regular appraisals took place which included a personal development plan. This was in line with the practice objective of "ensuring all staff have the skills necessary to perform their duties and providing the opportunities for continuous professional development to maintain and build on those skills". The practice had employed two trainers from 22 September 2014 to deliver its commitment to training, and a new training plan had been created and used in the induction of new staff.