Elmwood Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Elmwood Medical Centre on 20 October 2014. The practice operates from 7 Burlington Road, Buxton, Derbyshire SK17 9AY. This was a comprehensive inspection.

This practice has an overall rating of good.

Our key findings were as follows:

- The service was safe in all areas. Staff understood their responsibilities to raise concerns and report accidents, incidents and near misses. Opportunities to learn from internal and external incidents were analysed and used to support improvement.
- The service was effective. Elmwood Medical Centre had sound clinical systems in place to ensure effective service delivery. This included regular clinical meetings with recorded discussion and learning points. In addition the practice followed local and national guidelines and best practice such as National Institute for Health and Care Excellence (NICE) guidelines.
- The service was caring. Data from the patient's survey showed that patients rated the practice higher than others locally and nationally. For example patients spoke positively about their experiences of receiving care from their GP.
- The service was responsive. The practice was open to considering alternative methods of meeting patient's needs and ensuring that referrals were made to hospital or other services in a timely manner.
- The service was well-led. There was a stated vision for the practice, and clear lines of accountability and leadership in place. Complaints and concerns were addressed and learning points were used by the staff to make improvements.

We saw areas of outstanding practice including:

Summary of findings

- The practice offered in-house acupuncture by one of the GP partners as part of its approach to pain management as part of the National Health Service provided.
- The practice had developed their own risk assessment tool to identify which patients aged over 75 were most at risk of avoidable unplanned admissions. North Derbyshire clinical commissioning group (CCG) had expressed an interest in using the tool at other practices.

However, there were also areas of practice where the provider should make improvements.

The provider should:

- The provider should have an effective system to assess the risk of, prevent, detect and control the spread of health care associated infection and ensure that any risks are identified.
- The provider should carry out a review of security at the practice and consider the risks to staff, patients, and resources.

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?

The practice is rated as good for providing safe services.

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

However, we found that the practices' infection control procedures did not follow the published guidelines for best or safe practice. The practice did not monitor the standard of hygiene and infection control provided by their external cleaning contractor. Following our inspection the practice informed us they had taken measures to address the infection control shortcomings.

Are services effective?

The practice is rated as good for providing effective services.

Good

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely.

Gillick competencies were used by the GPs to assess the treatment offered to children under the age of 16 and the practice had a clear policy and procedure in place for dealing with issues of consent.

There were regular multi-disciplinary palliative care meetings held to share information and ensure continuity of care.

Established protocols were used for sharing information and ensuring continuity of care when a patient had been seen by the out-of-hours service.

The practice offered a travel service with vaccinations and inoculations for patients travelling abroad. This included inoculation against yellow fever, although this was offered as a private service in line with other services offering yellow fever vaccinations across the UK.

Are services caring?

The practice is rated as good for providing caring services.

Good

Data from the patient's survey showed that patients rated the practice higher than others locally and nationally for several aspects

Summary of findings

of care. Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Senior staff at local care homes stated that GPs were caring and compassionate.

There were systems to ensure effective communication with patients whose first language was not English. In addition efforts had been taken to assist those patients with access issues or mobility issues by the provision of level access to ground floor surgeries; a hearing loop for the hearing impaired and assisted toilet facilities.

The practice had a lead GP for bereavement and palliative care, and took an active role in supporting patients at this stage of their lives.

Senior staff at local care homes who received a GP service from Elmwood Medical Centre stated that GPs were caring and compassionate.

Are services responsive to people's needs?
The practice is rated as good for providing responsive services.

Good

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The practice had initiated service improvements for its patients that were over and above its contractual obligations such as offering in-house acupuncture to help patients with pain management. The practice had also developed their own risk assessment tool to identify which patients aged over 75 were most at risk of avoidable unplanned admissions to hospital or long-term care. North Derbyshire Clinical Commissioning Group (CCG) had expressed an interest in using the tool at other practices

The practice had good facilities and was well equipped to treat patients and meet their needs. There was an active patient participation group (PPG) who had a role in supporting the practice and reflecting the patient voice. As a result the practice responded to issues identified with the appointment system, and patients told us access had improved.

Patients with long-term conditions were monitored by the practice and offered annual health checks and medication reviews where appropriate.

The practice had a system in place for handling complaints and concerns and there was a designated responsible person who handled all complaints in the practice.

Are services well-led?
The practice is rated as good for providing well-led services.

Good

Summary of findings

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

Elmwood Medical Centre was offering an enhanced service to older patients. This focussed on avoiding unplanned admissions to hospital by having a named GP and an individual care plan for each patient over the age of 75.

The practice worked closely with a community matron and a care co-ordinator to promote integrated and consistent care for older people.

The district nurse attached to the practice provided influenza vaccinations to elderly patients at home who were housebound.

There were nine care homes for older people within Buxton, who have patients registered at Elmwood Medical Centre. We spoke with staff at three of those homes and were told that the practice offered a good service. Two homes commented on the GPs good bedside manner, and all three said that they had no concerns.

People with long term conditions

Good

The practice had a continuous programme of reviews for patients with chronic diseases by the practice nurse. Patients with the most complex needs were cared for using a multi-disciplinary approach involving GPs and appropriately trained care professionals.

The practice had good links with the community diabetic nurse, the heart failure nurse and the respiratory nurse. This allowed for patients getting co-ordinated care and support.

One GP partner had an interest in chronic pain management, and was trained in acupuncture therapy. Many of the patients who were experiencing pain as part of their long-term condition were able to receive in-house acupuncture which acted as a complimentary therapy to the management of their long-term condition. The practice offered acupuncture as a part of its NHS service.

Families, children and young people

Good

Patients at the practice who were new mothers received ante-natal care from the community midwives. The practice also had a health worker who liaised closely with families and linked into practice meetings.

Childhood immunisation rates at the practice were at or above the CCG average.

Summary of findings

We saw good examples of joint working with midwives, health visitors and school nurses.

Emergency processes were in place for children and pregnant women whose health deteriorated suddenly. For example any sick children coming into the practice were offered an appointment the same day or put through to speak to an on-call GP at the practice.

Working age people (including those recently retired and students)

Good

Appointments were available from 08:00 am to 18:30 pm on weekdays. However on a Wednesday the practice opened at 07:00 am and on a Tuesday remained open until 19:45 pm. This enabled patients access to the GP practice outside of the normal working day.

The practice offered a full contraception service including fitting both coils and implants. The morning after pill was also available if required.

People whose circumstances may make them vulnerable

Good

Patients who had a learning disability were offered an annual health check as part of the General Medical Services (GMS) contract with NHS England.

The practice had installed a hearing loop to aid those patients who were wearing a hearing aid. In addition the practice had access to sign language specialist and they had been used to communicate with patients who were deaf or who had a profound hearing loss.

The practice said they did not have any patients registered who were homeless and Buxton did not have any traveller sites. However, Buxton attracted tourists and occasionally the practice had registered holiday makers as temporary patients.

People experiencing poor mental health (including people with dementia)

Good

Patients experiencing poor mental health were offered an annual health check. There were well established links between the practice and the crisis team and there were a number of examples were this had worked well to help and support a patient experiencing a mental health crisis.

All GPs at the practice had experience of working on rotation at Spencer ward at the Cavendish hospital in Buxton. Spencer ward provides older people's mental health services. This experience had improved the practice's knowledge and understanding of the needs of older people with mental health issues.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 38 completed comment cards. 35 were positive, expressing views that the practice offered a good service with understating, caring and compassionate staff. The three negative comment cards also carried some degree of praise for the practice, although two said it could be difficult to get an appointment, while the third focussed on a specific issue relating to prescriptions.

The practice had used an external company to conduct its patient survey. The data collected related to a two week period in early 2014 and showed that 235 patients had taken part. Comments were generally very positive, with 85% of respondents indicating they were satisfied with the care and treatment they received.

We spoke with four patients during our inspection. All four patients said they were happy with the care they received, and thought all of the staff were friendly, welcoming and caring. Information collected through NHS Choices and compared nationally indicated 89% of patients surveyed said the last appointment they got was convenient, 85% of those patients said the last GP they saw was good at treating them with care and concern. In addition 91% said they had confidence and trust in the last GP they saw.

We received information from Healthwatch Derbyshire about the practice. One patient had contacted Healthwatch and provided positive feedback, particularly in respect of the staff. They did also comment that consultation times were short and the electronic booking in system was difficult for older patients to use.

Areas for improvement

Action the service SHOULD take to improve

The provider should provide an effective system to assess the risk of and to prevent, detect and control the spread of health care associated infection.

The provider should carry out a review of security at the practice and consider the risks to staff, patients, and resources.

Outstanding practice

One of the GPs at the practice had an interest in acupuncture and pain management. This benefited patients at Elmwood Medical Centre in that they were offered acupuncture as part of the Personal Medical Services (PMS) contract provided if clinically indicated and appropriate.

The practice had developed their own risk assessment tool to identify and assess patients aged over 75 who were most at risk of avoidable unplanned admissions. The risk assessment had identified 2% who fell into the 'most at risk' group. The North Derbyshire Clinical Commissioning Group said they wanted to use the practices' risk assessment and share it with other practices.

Care Quality Commission

Elmwood Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included one GP and one specialist practice manager.

Background to Elmwood Medical Centre

Elmwood Medical Practice provides primary medical care services to approximately 8,500 patients. The practice is based in a building close to the centre of Buxton, in the Peak District of North Derbyshire.

The practice does not offer a dispensary service. However, patients can access medicines from an independent pharmacy located within the same building as the practice.

The practice has a Personal Medical Services (PMS) contract with NHS England. This is a contract for individual GPs to deliver primary care services to the local community or communities.

There are six GPs at the practice, five partners and one salaried GP. There are four male GPs and two female GPs. In addition the nursing team comprises of two nurse practitioners, two further practice nurses and two healthcare assistants. The clinical team are supported by the practice manager and an administrative team. Two GPs work slightly less than full time, as a result there are nearly five and a half whole time equivalents working at the practice.

Minor surgery is performed by the practice's GPs at the nearby cottage hospital. This location was not inspected as part of this inspection.

Elmwood Medical Centre has opted out of providing out-of-hours services to its own patients. Out-of-hours services are provided by Derbyshire Health United.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before under our new inspection process and that was why we included them.

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

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 October 2014. During our visit we spoke with a range of staff (GPs, nursing staff and administration and reception staff) and spoke with patients who used the service. We observed how people were being cared for and talked with patients We reviewed comment cards where patients shared their views and experiences of the service.

During our inspection we found that any minor surgery that patients required was completed at the local cottage hospital. We did not inspect minor surgery as part of this inspection.

Our findings

Safe track record

The Health and Social Care Act (2008) identifies incidents and circumstances that must be notified to the Care Quality Commission (CQC). Up to the start of our inspection Elmwood Medical Centre had not sent any notifications to CQC during 2014. Discussions with the practice manager identified that no events had taken place that would have required notification to CQC.

The practice used a range of information to identify risks and improve patient safety. For example the practice had an accident book to record accidents that occurred to staff or patients. On reviewing the information we saw that there had been no accidents recorded during 2014. There was also information available relating to Reporting of Injuries, Diseases, and Dangerous Occurrences (RIDDOR). There is a statutory obligation to report deaths, injuries, diseases, and dangerous occurrences including 'near misses' that take place at work or in connection with work. The documentation showed that no RIDDOR reports had been made by the practice during 2014.

During our inspection we were able to check safety records going back over several years. These included the accident records, fire safety records, and health and safety audits. The records identified that the practice had a good track record with regard to safety.

Discussions with four patients at the practice identified that they had no concerns regarding safety at the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We discussed significant events with a GP and the practice manager. They stated that significant events were discussed at partnership meetings whenever they arose, and were a standing item on the agenda. This was evidenced during our inspection. Prior to our inspection the practice sent us a summary of significant events that had occurred in the previous twelve months. The summary identified that eight significant events had occurred since November 2013. All of the events had been analysed and learning points had been highlighted. The action taken by the practice identified that the practice had learnt from the significant incidents and patient safety had improved as a result. For example a patient had a cervical smear; however the wrong (out-of-date) container was used for the smear. This was discussed at a partners meeting and the smear test was repeated. The old out-of-date containers were removed from rooms.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had an identified lead GP for safeguarding who was trained to the appropriate level. We reviewed the staff training records which showed that most of the staff at the practice had received training in safeguarding children and vulnerable adults in February and May 2014. Those staff who had not received this training had been identified and further training was being booked.

We spoke with two receptionists who were able to explain some of the different types of abuse and knew what to do if they had safeguarding concerns. The practice manager also showed us that information relating to safeguarding was available on the intranet (the practice's internal computer information system). We saw that contact numbers for the local authority, who have the lead role with regard to safeguarding, were available for staff.

The practice explained there were some children registered at the practice who were 'at risk.' A GP told us that all 'at risk' children were flagged on the computer and their notes reflected their 'at risk' status. This was evidenced during our inspection. A monthly meeting was held to discuss all children who were identified as being 'at risk'. The monthly meetings were held with health visitors and where appropriate school nurses. Minutes of these meetings were available and we saw that the practice took measures to safeguard 'at risk' children in their care. The GP also said that occasionally reports were requested for child protection meetings and these were always completed and submitted when requested.

Posters explaining the chaperone arrangements were prominently displayed around the practice to inform patients. Discussions with staff outlined their understanding of the role of a chaperone and staff were able to say why this was important. The staff training records identified that staff designated as chaperones had

been trained in the role. As a result patients could be assured that any chaperone who accompanied them to a consultation understood the role of a chaperone. Discussions with a GP about chaperones identified that if a chaperone had been present would be recorded in the patient's notes.

Medicines management

We inspected the emergency medicines held by the practice. We found they were stored securely and were within their expiry date. The emergency medicines were checked regularly and this was recorded. New medication supplies were ordered before the old stock had passed its expiry date.

The practice had carried out a number of audits of medicines being prescribed to patients. A summary of the audits had been sent to CQC prior to the inspection. The practice had audited the use of non-steroidal anti-inflammatory drugs (NSAID's). These are commonly prescribed medicines used as pain killers (analgesics) and for treating inflammation. However, there are risks associated with their long-term use, which had prompted the practice to carry out a good practice audit. The main learning points were to avoid NSAID's in renal failure if possible and whether they are prescribed for use in the lowest effective dose.

Cleanliness and infection control

Patients told us they felt the practice was clean. We saw that clinical and communal areas including the toilets appeared visibly clean. Staff said there was a cleaning contract in place with an external company.

Any organisation with public access to their water system has a duty to have a risk assessment in place to ensure Legionella does not become a danger to health. Records showed the water at the practice was 'flushed' through the system on a weekly basis, which is good practice for preventing Legionella. However, certification showing the water systems had been tested for Legionella were not available for inspection.

The practice had a lead member of staff for infection control. However, on reviewing that staff member's training records we saw that they were not up-to-date with their infection control training. We were informed by the practice after the inspection that the lead person for infection control was due to undertake refresher training on 4 November 2014.

We identified there was a need to reduce the risk of cross infection at the practice. For example there was scope to improve infection control practice in the toilet areas. Staff training in infection control was not up-to-date for all members of staff. The practice had not completed necessary audits that would allow for an assessment of the risks. This included auditing of the contracted cleaner, and checking that cleaning equipment was clean and stored appropriately.

Infection control audits were not being completed regularly, and the practice did not have a robust infection control policy, as the policy did not highlight actions to be taken and by whom.

The practice did not have a copy of the code of practice on the prevention and control of infections and related guidance at the time of our inspection, although a copy was acquired very soon afterwards. The code of practice gives clear guidance on what good infection control policy and practice looks like.

Following our inspection the practice manager informed us that the practice was carrying out a full review of its infection control procedures.

Equipment

The practice had a range of different equipment including a refrigerator and a defibrillator. A defibrillator is a machine for providing electric shocks to re-start the heart in an emergency. We saw documentation relating to checks of the equipment, and we also saw maintenance agreements were in place where required.

There was evidence to show that equipment such as thermometers, blood pressure machines, and weighing scales had been calibrated to ensure clinical staff could make accurate judgements when assessing their patients.

All electrical equipment with a plug had been tested. The testing had been carried out by an external contractor and records were available for inspection. Most electrical equipment had a sticker identifying when it had been tested. Regular Portable Appliance Testing (PAT) of electrical equipment reassured the provider that electric equipment was safe.

A visual check of equipment at the practice did not raise any concerns.

Are services safe?

Staffing and recruitment

During the inspection we reviewed seven staff files to check that safe recruitment protocols had been followed. We did not identify any concerns with regard to the recruitment of staff. The documentation we would expect to see that would demonstrate safe and effective recruitment was present. This included: proof of identification, a photograph, interview notes, a curriculum vitae (or application form) and evidence of a police check or risk assessment (A Disclosure and Barring Service check – DBS.)

We saw the staffing rota for the practice and this identified there were sufficient numbers of suitably qualified and experienced staff to meet the needs of the patients. We saw how staff were allocated, and how planned or sudden shortages were anticipated and covered.

Monitoring safety and responding to risk

There were systems to identify, assess and manage risks relating to the health, welfare and safety of patients and others.

Security within the building was not robust. It was possible to move around the entire building unchallenged by locked doors or keypads. This included staff areas and upper floors of the building. There was a potential risk to staff safety, information security and physical resources which had not been identified. For example we saw that dressings were stored in an unlocked cupboard in an unstaffed area of the building.

Discussions with reception staff showed there were emergency processes in place for patients with long-term conditions. If a patient became unwell in the waiting area staff said what action they would take, and this included contacting a GP or nurse or dialling 999 for an ambulance. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. Reception staff said that an alternative waiting area was available away from the main waiting room, and the practice had links with the local mental health teams for GPs to make secondary referrals if necessary.

The arrangements in place for ensuring there were safe systems to prevent fire were robust and this demonstrated that the risks associated with fire safety were given a high priority and were well managed at the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support in October 2013. The practice manager showed us that refresher training for all staff had been identified and was booked. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Staff also confirmed that using the defibrillator had been covered during the basic life support training.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest (heart attach), anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). The practice also held stocks of other medicines for the treatment of emergency situations. For example penicillin for treating meningitis. We were assured that a full risk assessment had been undertaken and a protocol was in place to manage this. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan had been reviewed and was up-to-date.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this in that there were suitable arrangements in place to ensure the service would continue in the event of adverse weather.

Are services safe?

Most of the staff lived within walking distance of the practice, and the practice manager assured us that bad weather had not unduly affected the practices' operation in the past.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could easily outline the rationale for their approaches to treatment. They were familiar with current best practice such as NICE guidance and locally identified best practice. There were regular clinical meetings held which evidenced a team approach.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma with support from the practice nurses. This allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for, and providing colleagues with, advice and support.

A GP partner showed us data from the local CCG of the practice's performance in areas such as antibiotic prescribing, which was comparable to similar practices. The practice had also completed a number of clinical audits in areas such as anticoagulation in Atrial Fibrillation, long term usage of Bisphosphonate and an audit of the use of Diclofenac. The audits were used by the practice to ensure that patients were receiving appropriate treatment and regular reviews. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs evidenced that the culture in the practice was that patients were referred based on need and in a non-discriminatory manner.

Data received from the CCG indicated that the referral rates for patients to secondary care compared favourably with other practices in the local area.

Management, monitoring and improving outcomes for people

The practice had a formal system in place for completing clinical audit. The practice sent us a summary of the clinical audits that had been completed during 2013/14. There were nine different audits of a clinical nature during that time. These included: the use of non-steroidal anti-inflammatory drugs (NSAID's) in heart failure and renal failure and an audit of the use of the medicine Diclofenac. We were able to see how learning points had come from each clinical audit with action points for the relevant staff.

The practice's policy was to discuss ideas and outcomes of audits during a combined GP/nurse team meeting. These meetings occurred once per month and the audit discussions were inserted as required. A clinician was nominated to lead the audit. Discussions with clinical staff showed that there would be a re-audit to demonstrate improvement and progress and to complete the clinical audit cycle.

The practice also used the information collected for the quality and outcomes framework (QOF). QOF is a voluntary national performance measurement tool used to compare performance against national screening programmes to monitor outcomes for patients. For example: 97.9% of patients with diabetes had received an influenza vaccination; he practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (COPD – lung disease) and stroke and ischaemic attacks. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Are services effective?

(for example, treatment is effective)

Effective staffing

We checked the staff personnel files for seven members of staff. We saw that where the staff member had a professional qualification checks had been undertaken to ensure they were registered with their professional body. We saw that all six GPs at the practice had revalidated or had a date for this to take place. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with NHS England.

We reviewed the staff training records at the practice. Most staff had received up to date training in fire safety and resuscitation, which included use of the defibrillator. Staff members told us there were good training opportunities at the practice; one person gave an example of child protection training for the administrative staff that had been delivered by one of the GPs. They said they found this very useful and the training had prompted good discussions among the staff.

The practice had a meeting room situated on the top floor of the building. This room was used for staff training and in house Quality Education & Study Time (QUEST), training and development sessions. We noted that there was a small library of books and documents available as a training resource for staff. Staff told us that training sessions were often used to share information within the practice.

All staff undertook annual appraisals that identified learning needs from which action plans were documented.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, nurses were administering vaccines and travel medicines. Those with extended roles such as seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

Practice staff told us there were systems for making referrals to other services. There were contact details for clinics and hospital services and information to guide staff in making a referral to these services. The practice used the Docman workflow system for their correspondence. This was a computerised system that generated letters and could track the progress of correspondence, providing an audit trail for the clinical staff.

Staff told us the results of blood tests were not shared with a patient until they had been reviewed by a GP. If necessary a GP would state whether an appointment was required for further investigation or to discuss the results. All clinical information such as pathology results and letters were always screened, coded and actioned by GPs.

Another provider delivered the out-of-hours service for the practice. Information was received from the out-of-hours service when they had seen any patients registered at the practice. A GP told us information received from the out-of-hours service would be checked and recorded within 24 hours of receipt, usually this was done during the morning it was received.

The lead GP told us that patients receiving palliative care were discussed at monthly multi-disciplinary meetings with the other health care professionals. We saw the minutes of those meetings to evidence they had taken place.

Information sharing

All staff at the practice had access to the practices' computer system at a level appropriate for their role. This allowed all staff to access the policies and procedures for the practice. In addition: minutes of meetings, training resources and other information that would support each staff member to fulfil their role were available. We saw that, for security, each staff member had their own individual log in and password for the computer system.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, using the Choose and Book system. (Choose and

Are services effective?

(for example, treatment is effective)

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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

We spoke with four patients at Elmwood Medical Centre. The patients told us that they were happy with the way GPs and nurses gained consent and could evidence this with examples.

The practice is registered to provide minor surgery, however this did not take place at Elmwood Medical Centre. Any patients who required minor surgery went to the local cottage hospital where they would see one of the GPs from the practice. A GP explained that the cottage hospital was better equipped for performing minor surgery and it made sense to use the facilities when required. The GP explained that any patient undergoing minor surgery would routinely be asked to sign a consent form.

GPs were in the process of receiving training about the Mental Capacity Act (2005) (MCA) and best interest decisions. Half of the GPs had completed this training and plans were in place for the rest to undertake this. Nursing staff had not completed this training although the practice manager said they would be added to the training schedule. GPs were able to demonstrate an understanding of the MCA and the implications of providing care to vulnerable patients that might be seen in the practice. One GP gave a specific example which demonstrated that the MCA had been used in practice.

The practice had a consent policy in place which provided guidance to staff when they gave care and treatment to patients. The consent policy made reference to the Gillick competency for assessing whether children under 16 were mature enough to make decisions without parental consent. This allowed professionals to demonstrate that they had checked a person's understanding of proposed treatment, and used a recognised tool to record the decision making process.

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. This despite not all staff having received the training. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios, where capacity to make decisions was an issue for a patient; the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported in making their own decisions and how these should be documented in the medical notes.

Health promotion and prevention

New patients were seen as part of the registration process. During this consultation new patients would be offered a health check by a nurse, and then would be seen by a GP if appropriate. New patients were able to register through the practice website, with a registration form and health and lifestyle questionnaire available as part of the registration process. The questionnaire covered health information and family medical history as well as alcohol consumption and smoking.

There were information leaflets and posters in the practice promoting good health and encouraging patients to adopt a healthy lifestyle. The practice website www.elmwoodsurgery.co.uk also carried information on health issues and staying healthy for men, women and seniors.

The practice also offered NHS Health Checks to all its patients aged 40-75. A GP showed us how patients were followed up within two weeks if they had identified risk factors for disease at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check with a health care assistant. The practice had also identified the smoking status of its patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients.

Are services effective?

(for example, treatment is effective)

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG. There was a clear policy for following up non-attenders by the named practice nurse.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that patients were treated with dignity, respect and compassion by staff. The reception staff were polite, courteous and welcoming. 35 comments received on 38 completed comment cards indicated the staff were professional, polite and helpful. Comments from patients also indicated that there had been improvements in how reception staff engaged with patients. The three comments which contained negative comments also included some positive comments.

Patient records were stored securely and there were systems and practices in place to protect the confidentiality of information. Reception staff were aware of the need for confidentiality and told us that a private room was available if required. Most telephone calls to the practice were received in a room away from the public areas of the practice. As a result patients were not able to overhear telephone conversations received by the practice in this room, which promoted patient confidentiality.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

We reviewed patient survey information from two different sources. The information showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 75% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were above average compared to the local CCG area. The results from the practice's own satisfaction survey showed that 88% of patients said their GP was good at listening.

The practice's own patient survey had been completed by an external company. The data related to August 2013 and indicated that 235 patients had completed the survey. The information showed patients responded positively to questions about the practice. A comparison with 135 practices completing the survey across the country showed that Elmwood Medical Centre consistently scored in the top 25% for 19 of the questions asked on the survey. The remaining 9 questions scored in the middle 50% when compared to the other practices. Data from the national patient survey showed 85% of practice respondents said they were satisfied with care they received.

The patients we spoke with said that the staff were caring. The practice had access to a sign language service, and this had been used in the past for patients who were deaf or who had a profound hearing loss. Discussions with a member of the reception staff showed they were aware of this service, and the need to book a sign language interpreter when particular patients made an appointment.

We saw there was a hearing induction loop to assist patients who used a hearing aid. Information to reflect that a hearing loop was installed was on display in the waiting room and reception. Hearing induction loops are required 'where reasonably possible' by the Equality Act (2010).

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 69% of respondents to the patient participant group survey said they had received a second opinion or a referral to complimentary therapy to help them manage their treatment and care when it had been needed. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. Information provided by the North Derbyshire Clinical Commissioning Group (CCG) and through the Quality and Outcomes Framework (QOF) showed that referral rates to hospital and other services compared favourably with other practices in the local area.

One of the GPs at Elmwood Medical Centre had an interest in chronic pain management, and had qualified as an acupuncturist. Acupuncture is a treatment derived from ancient Chinese medicine in which fine needles are inserted at certain sites in the body for therapeutic or preventative purposes. Acupuncture has been shown to be beneficial for patients who have been experiencing pain; the practice offered this service as part of their NHS service.

We saw that Elmwood Medical Centre had tried to respond to the needs of patients in each of the population groups we considered. Health checks and medication reviews were available and offered to patients who needed these to ensure their long term conditions were well managed. The patient's notes alerted the GP when this was due. The practice was looking at ways to avoid admission to hospital or into long term care for its elderly patients through an enhanced service. As a result patients who fell into this group had an individual plan and the practice had developed their own risk assessment tool to identify high priority patients. The risk assessment had identified 2% who fell into the 'most at risk' group. The North Derbyshire CCG had said they wanted to use the practices' risk assessment, and to share it with other practices, however they had not yet done so.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There were facilities for mothers and young children, with baby change facilities available in the practice. The patients' toilets were accessible to wheelchair users and those with restricted mobility.

The practice held a register of all patients at the practice that had a diagnosed mental health condition. Annual physical health checks were offered and there was a recognition that people with mental health needs may have a higher risk of certain physical health conditions.

The practice offered home visits to their patients based on need. Usually this was for older patients or housebound patients.

The practice staff told us they used interpreters provided by Language Line to make sure that patients could communicate effectively with practice staff. Language Line is a telephone interpreting service widely used across the UK. We saw posters and leaflets about Language Line in the waiting room. Staff said that there was not a great call for the use of interpreters, as very few of the patients registered at the practice did not have English as their first language. However, staff were aware of Language Line and how to use it. One staff member said it was good to know it was there if they needed it. The practice had also made use of a sign language interpreter using British Sign Language (BSL).

Access to the service

The recent patient survey which was dated August 2013 was available on the practice website together with analysis of the patient survey. 68% of respondents said they were satisfied with the practice opening hours. 51% said they were satisfied with the telephone access, although the overall satisfaction with the appointments system rose to 72%. Of these only the telephone access (51%) fell below the national average (57% for telephone access).

Of the 38 comment cards we received, seven made reference to appointments. Some patients said it was not easy getting an appointment, others said appointments sometimes ran late. Discussions with patients identified that the appointments system had improved, although two patients thought there was still room for further improvement.

Appointments were available from 08:00 am to 18:30 pm on weekdays. However on a Wednesday the practice opened at 07:00 am and on a Tuesday remained open until 19:45 pm. This to allow patients access to the GP practice outside

of the normal working day. Early appointments on a Wednesday and the late appointments on Tuesday were bookable in advance. Telephone access was between the hours of 08:00 am and 18:30 pm Monday to Friday.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. One patient said that this was not easy for elderly patients and that ringing the surgery was the best option. However, we saw evidence of how the practice had addressed this problem positively utilising the help of their patient participation group (PPG).

There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and for those with long-term conditions. This included appointments with a named GP or nurse. Home visits were made to nine local care homes for those patients who needed a home appointment.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. There were leaflets and a poster available in the reception waiting area to inform patients about how to complain.

Prior to our inspection we asked the practice for a summary of the complaints they had received in the last year. The summary identified six complaints had been received between March 2014 and September 2014. We saw from the summary, and afterwards at the practice that learning points had been identified where appropriate. The records showed that the complaints had been responded to in a timely manner, and in line with the practice's complaints procedure.

Complaints were discussed at the practice meetings. We saw the minutes of a practice meeting which made reference to complaints that had been received. Complaints had been analysed to see if there were any trends or themes. The analysis showed that there were no recurring themes among the complaints.

Are services well-led?

(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 deliver high quality care and promote good outcomes or patients. During our inspection we saw examples of the practice putting their stated vision into practice. For example, we identified four patients whose care was personalised and who said they felt their specific needs were being met. The use of alternative approaches, particularly the use of acupuncture at the practice, showed both innovation and a commitment to the needs of individual patients.

Prior to our inspection the practice sent us a copy of their statement of purpose. This document set out the aims and objectives of the practice and gave an overview of how the practice would operate. Staff were aware of the statement of purpose and two staff members could recount the practice vision.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures; all eight had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example a clinical correspondence audit, a Buxton minor injuries unit audit and an audit of the long term use of Bisphosphonate. Following these audits learning points were identified and clinical and practice systems improved.

Leadership, openness and transparency

We discussed the arrangements for external peer review of GPs which was done through monitoring by the Clinical Commissioning Group (CCG) and GP appraisals.

Our observations and discussions with staff at the practice showed there was a team approach towards service delivery. Regular team meetings were held at the practice, we saw minutes of meetings to evidence this. We saw that GPs had been involved in delivering training to all grades of staff, which had helped with team bonding.

Staff told us they felt well supported and were able to express their views and opinions. Staff meetings were open and were a forum for sharing information and discussion.

Following feedback at the end of the inspection, the GP and practice manager showed a willingness and commitment to the highlighted issues needing improvement.

Practice seeks and acts on feedback from its patients, the public and staff

The practice carried out an annual patient satisfaction survey over a two week period. This was completed on their behalf by an external survey company. The survey allowed for comparisons to be made between practices nationally. The results of the last satisfaction survey were dated August 2013. The practice manager said the next survey was due to be completed within the next four months. The data showed that 235 patients took part in the last survey and answered 28 questions about the practice, the GPs and the staff. In all areas apart from one (telephone access) the practice scored as well or better than the national average when compared to practices across the country.

We met with a member of Elmwood Medical Centre's patient participation group (PPG). The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

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The PPG was very active and the group met approximately every three months. The practice website said that the PPG had 34 members. In addition, patients were encouraged to share their views through a virtual group whose views and opinions were gathered by e-mail. The PPG had been focussed on attracting more members, particularly from

patient groups that were not well represented. To address this, the PPG had put information about their role and was trying to recruit new members on the back of prescriptions collected by patients. They had put up posters in the waiting room and sent out a leaflet with all patient letters leaving the practice.

The practice website listed some of the PPG's achievements: they had gained patient views on the appointment system to trigger improvements; they had been involved with practice staff to improve telephone access and restart text appointment reminders; they had also joined with other High Peak PPGs on issues of common interest.

The issue of access to appointments had been highlighted through the patient survey, and the PPG had worked in partnership with the practice staff and had prioritised this area as a focus for improvement.

The practice manager had given a clear statement of commitment to working proactively with the PPG on the practice website and the PPG members confirmed GPs attended their meetings.

Management lead through learning and improvement

We saw a clear understanding of the need to ensure that staff had access to learning and improvement opportunities. As a result there were training opportunities both within Elmwood Medical Centre and externally. The practice ran monthly QUEST (Quality Education & Study Time) training and development sessions for all staff. Newly employed staff had a period of induction as did any locum staff. Learning objectives for existing staff were discussed during appraisal.

Nurses and GPs kept their continuing personal development up to date and attended other courses relevant to their roles and responsibilities within the practice. This ensured that patients received treatment which was most current.

The NHS friends and family test (FFT) was introduced in 2013. It provides an important opportunity for patients to provide feedback on the care and treatment they receive and to improve services. Information and feedback forms for FFT were available on the practice website. Information from FFT is being managed by NHS England. From December 2014 FFT will form part of the GP contract. The FFT was being used at the practice, although it was too early into the process to evaluate patient feedback.