Manor House Surgery Hadfield

Quality Report

82 Brosscroft
Hadfield
Derbyshire
SK13 1DS
Tel: 01457 860860
Website: www.manorhousesurgery.co.uk

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

Ratings

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

Summary of findings

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Overall summary

This practice is rated as Outstanding overall.
(Previous inspection April 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Outstanding

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

Older People – Outstanding

People with long-term conditions – Outstanding

Families, children and young people – Outstanding

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

People whose circumstances may make them vulnerable – Outstanding

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

We carried out an announced comprehensive inspection at Manor House Surgery Hadfield on 11 January 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw several areas of outstanding practice including:

- The practice used new tools and tests to improve outcomes for patients, for example C-reactive Protein (CRP) tests to reduce unnecessary antibiotic prescribing and introduced Exhaled Nitric Oxide (FeNO) to maximise asthma management for patients led by the advanced nurse practitioner. Since initiating FeNO early results showed improved symptom control, reduced exacerbations and hospital admissions. Of 203 tests audited, 33 patients had medication reduced, 11 patients had medication stopped, 50 patients had medication increased and 35 reported improvement in their symptoms.

Summary of findings

- The practice worked closely with colleagues from adult social care (ASC) to support patients and their carers. We noted at any one time the practice was engaged jointly in coordinating the care of around 50 patients. We were told by the ASC the involvement of the practice was unique and the joint working enabled positive outcomes for patients. We were provided with numerous examples especially in relation to end of life care where joint working was crucial but also examples of enabling patient with dementia to remain at home or where patients in crisis due to mental health accessed swift coordinated response led by the GP.
- The practice initiated a minor injuries service with aim to provide the treatment direct to the presenting patient rather than referring on to the A&E for their management. Data provided by the practice showed of 77 patients treated under the scheme only 5 patients were sent to A&E, 45 were examined and given advice and 20 were sent direct for and x-ray.
- The practice worked closely with The Bureau (Glossop's Voluntary & Community Network who work to support people to stay physically and socially active, improve mental wellbeing and live independently for longer.) to launch social prescribing (community navigation) as a single point of contact to offer support to patients with their health and social needs. The Bureau, hold a drop in session and booked appointment at the practice weekly. The aim was to reduce repeat attendances and multiple GP appointments where the issues were social. Data provided by the practice showed 23 social referrals have been made by GPs as well as staff promoting the drop in sessions. Evaluation by The Bureau in November 2017 showed Manor House Hadfield were actively engaged in social prescribing and had referred patients for a range of support including mobility, anxiety/depression, loneliness and social isolation.

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

Summary of findings

The six population groups and what we found

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

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

Manor House Surgery Hadfield

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser.

Background to Manor House Surgery Hadfield

Manor House Surgery Hadfield is the registered provider and provides primary care services to its registered list of approximately 3200 patients. The practice delivers commissioned services under the General Medical Services (GMS) contract and is a member of Tameside and Glossop Clinical Commissioning Group (CCG).

The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice offers direct enhanced services that include meningitis provision, the childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations, learning disabilities, minor surgery and rotavirus and shingles immunisation.

Regulated activities are delivered to the patient population from the following addresses:

82 Brosscroft

Hadfield

Derbyshire

SK13 1DS

The practice has a website that contains comprehensive information about what they do to support their patient population and the in-house and online services offered: www.manorhousesurgery.co.uk

The age profile of the practice population is broadly in line with the CCG averages. Information taken from Public Health England placed the area in which the practice is located in the seventh least deprived (from a possible range of between 1 and 10).

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice conducts an annual safeguarding audit. The recent audit resulted in the implementation of a DNA policy for children and young people which was shared throughout Tameside and Glossop CCG to improve safeguarding across the area.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. The safeguarding lead was trained to level five and was also the lead for the CCG.
- The practice had systems in place to support patients and their families who were at risk from domestic violence and worked with other local agencies to support patients holding appointments at the surgery where appropriate. Staff had received training in relation to domestic violence and we noted alerts were placed within patients records where necessary.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff, including temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, a sepsis template had been added to the clinical system and staff had received updates from the UK sepsis trust during clinical meetings.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- We saw in two clinical rooms full length window blinds were in place which had looped cords. We alerted the practice manager who told us they would risk assess the blinds and where necessary remove or replace with blinds which are compliant with the child safety requirements. The practice removed the blind following the inspection.

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- For patients at the end of life the practice used Electronic Palliative Care Co-ordination Systems

Good

Are services safe?

(EPaCCS) which places the patients' wishes at the centre of their care such as preferred place of death. EPaCCS enabled them to work together with other health and social care providers and out of hours services by sharing and having access to key information about patients ensuing coordinated joined up care for patients and their families. Care and treatment was co-ordinated and monitored using a detailed clinical tool which was updated and reviewed as part of multidisciplinary meetings.
- Referral letters included all of the necessary information and referrals were peer reviewed and discussed as part of clinical meetings.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. For example following an alert from Medicines and Healthcare products Regulatory Authority (MHRA) in relation to the use of oxygen cylinders, the practice implemented a failsafe instruction leaflet to attach to all oxygen cylinders used within the practice, communicated the key messages in the alert at a clinical meeting and provided oxygen cylinder training to all staff to ensure the safe operation of oxygen cylinders.
- A practice business continuity plan was in place.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as outstanding for providing effective services overall and for all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (01/07/2015 to 30/06/2016) was lower than other practices in England (practice 0.16% compared to England average 0.9%)
- The number of antibacterial prescription items prescribed (01/07/2015 to 30/06/2016) was half that of other practices in the CCG and England. The practice introduced C-reactive Protein (CRP) tests in March 2016, these are immediate result blood tests which showed if there were any bacterial infections present, in order to prevent inappropriate prescribing. This resulted in a reduction in antibiotic prescribing within the practice
- The practice also used the Tameside and Glossop antibiotic prescribing app and Greater Manchester Medicines Management Group (GMMMG) website which have also assisted in appropriate prescribing and a reduction in antibiotic prescribing.
- The percentage of antibiotic items prescribed that are Cephalosporins or Quinolones (01/07/2015 to 30/06/2016) was comparable to other practices in England.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice hosted multi-disciplinary team (MDT) meetings every 6 weeks, care was co-ordinated and planned and reviewed for high risk and severely frail patients The MDT comprised of GPs, a social worker, district and long term conditions nurses.
- The practice secured funding in 2015-2017 for the practice based pharmacist project which was to benefit all patients over 75 years of age registered with the practice. During this time 28% of the over 75s population received comprehensive reviews of their medications which improved the quality of prescribing, improved patients understanding of their medications, reduced risk to patients, improved patient experience. Formal funding ended in September 2017, however although a slight gap in services the scheme was rolled out across the CCG resulting in pharmacists from Prescribing Support Services working with the practice support older patients.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that included an assessment of asthma control using the three Royal College of Physicians (RCP) questions was 89%. This was above the CCG and national average (CCG - 76%, National - 71%).
- In 2016 the practice introduced Exhaled Nitric Oxide (FeNO) to maximize asthma management for patients led by the advanced nurse practitioner. Since initiating FeNO early results showed improved symptom control, reduced exacerbations and hospital admissions. Of the 203 tests audited, 33 patients had medication reduced, 11 patients had medication stopped 50 patients had medication increased and 35 reported improvement in their symptoms.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 86% (CCG and National 83%).
- The practice hosted weekly diabetic clinics, where care was co-ordinated planned and reviewed. The diabetes team comprised of a male and female diabetic specialist GP, specialist diabetic practice nurse, health care assistant and administrator. As a result the practice were ranked fourth out of 39 other practices in the overall achievements for all eight care processes for diabetes within the CCG, including foot checks (90%) and Cholesterol monitoring (95%).
- The percentage of patients with COPD who had had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 95% (CCG and National 90%)
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 86% (CCG and National 83%).
- The percentage of patients with atrial fibrillation in whom stroke risk had been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) was 99% (CCG - 98%, National - 97%).
- The practice worked with Self-Management UK to provide in-house 6 week support courses for patients with long term conditions. These included recent courses for patients with COPD and chronic pain.
- There was a dedicated link on the practice website for long term conditions which provided comprehensive information for patients on the following topics:- Asthma, cancer, COPD, coronary heart disease, diabetes, mental health, osteoarthritis, pain and strokes.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below the target percentage of 90% or above in three areas:
  - Percentage of children aged 2 with pneumococcal conjugate booster vaccine was 88%
  - Percentage of children aged 2 with Haemophilus influenzae type b and Meningitis C booster vaccine was 88%
  - Percentage of children aged 2 with Measles, Mumps and Rubella vaccine was 82%
- The practice has set up a small quality improvement focus group to look at where improvements can be made for childhood immunisations uptake, for example the practice reviewed all patients on the list. Out of 22 patients, 7 patients were from 3 families who have been spoken to on multiple occasions and have declined. The practice childhood immunisations letter was changed to be more strongly worded. With the measles outbreak the practice also produced a Facebook video which reached a wide audience and had 5.8k views.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The practice provided GP cover and registered patients from three local children's homes one of which provided care for children with complex physical needs. Priority appointments were available for these children and the lead GP liaised closely with the managers and held virtual MDT meetings to review and coordinate patient care. We saw written feedback from the manager of one children's home in which they praised the practice for the way in which they responded to the children's and family's needs in a caring manor and the way the practice were always willing to respond to any concerns the home may have.

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

- The practice's uptake for cervical screening was 86%, which was above the 80% coverage target for the national screening programme. To achieve this, the practice wrote to patients in need of cervical screening and clinicians were proactive in inviting patients to book a smear. In March 2016 the uptake for cervical screening was 83% as a result of these interventions this had increased to 86% in March 2017.
- The practice provides smear clinics on Thursday evenings to enable patients to attend at times best suited to their needs.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice offered all aspects of family planning, including contraceptive implants and coils at their other location nearby.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- Patients had access to appropriate health assessments and checks. The practice worked with the Derbyshire Federation and Derbyshire County Council to support access to appropriate health assessments and checks including NHS health checks for patients aged 40-74. The practice provided appropriate follow up on the outcomes of assessment checks where abnormalities or risk factors are identified.People whose circumstances make them vulnerable:
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice worked closely with social care and voluntary organisation to ensure a joined up approach to provide a holistic package of care.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had alerts within patient's records which also indicated patients with carers.
- The practice worked closely with the learning disabilities nurse in the community and supported patients living in a local supported living unit.
- The practice worked closely with a local hostel for women fleeing domestic violence, and would register patients and children using a PO BOX address to maintain confidentiality and the safety of patients.
- The practice also worked with their Patient Participation Group (PPG) to raise awareness of support groups and voluntary organisations for socially isolated and vulnerable patients. Examples included close links with The Bureau (a voluntary organisation whose services included supporting people to stay physically and socially active, improve mental wellbeing and live independently for longer.) who held weekly drop in sessions at the surgery.

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

- 98% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is above the national average of 84%.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the national average 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 100%; CCG 88%; national 91%)
- High risk patients are given a crisis plan to access emergency care/treatment or other support. We saw examples of where the lead GP worked closely with colleagues in the community and police where patients were in crisis and had a clear understanding of the Mental health Act and Mental Capacity Act.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.The most recent published Quality Outcome Framework (QOF) results (2016/17) were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The overall clinical exception reporting rate was 8% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice used information about care and treatment to make improvements. Monitoring and reviewing QOF and prescribing data as part of clinical meetings and using quality evaluation and quality improvement tools to monitor outcomes for patients.
- The practice was actively involved in quality improvement activity.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- The practice worked closely with colleagues from Adult Social Care (ASC) to support patients and their carers. We noted at any one time the practice was engaged jointly in coordinating the care of around 50 patients. We were told by the ASC team the involvement of the practice was unique and the joint working enabled positive outcomes for patients and resulted in the practice model being implemented into North Derbyshire. There was evidence of good team working, for example quick mobile and email links with ASC and the community specialist paramedic. The practice had a bypass telephone line to allow quick access to the practice from social services, district nurses, Macmillan nurses and paramedics allowing for seamless referrals and joined up working to improve outcomes for patients.
- We were provided with numerous examples joined up working with ASC and community services especially in relation to end of life care where joint working was crucial but also examples of enabling patient with dementia to remain at home or where patients in crisis due to mental health accessed swift coordinated response lead by the GP. We spoke with two social workers from the adult social care team and they told us they had a unique relationship with the whole practice which had a positive impact on patients and their carers. The Service Manager for ASC stated in correspondence to the practice they would be taking the learning from their work together and implementing these integrative approaches across other practices in North Derbyshire. Coordinating and improving end of life care was a key performance indicator for the practice. During 2017/18 they had established close working relationships with, Social Services, Macmillan Nurse, The Bureau and District Nurses to improve not only care at end of life but also, social prescribing, reduced hospital admissions and quicker discharges from hospital as well as improvement in bereavement support.
- End of life care and treatment was co-ordinated and monitored using a detailed clinical tool 'The Bolton Tool' (A Gold Standards Framework (GSF) database) which was accessible to all relevant parties and this information was used to coordinate and review care. The practice told us the tool helped to prompt areas that should be discussed at each stage of a patient's journey and key areas are discussed as a multidisciplinary team (MDT). The tool also identified how many patients were not known to any community teams other than the GP. To enable improved joint working for patients at the end of life they devised a holistic questionnaire to explore patient's current needs and all was added to the clinical tool.
- We saw that 80% of patients were able to have care provided in their place of choice at the end of life, for example at home or in a hospice.
- The PPG helped the practice create a leaflet on MDT working for patients.

Helping patients to live healthier lives

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway (practice 50%) was comparable to other practices in the CCG and nationally.
- One of the practice quality improvement schemes was to increase the uptake of bowel screening above the national average. To date the practice had achieved an uptake of 58.3%. The practice has worked with the PPG to devise a letter for patients, waiting room display and Facebook post. They also worked with the Greater Manchester Bowel Movement (GMBM) service to devise a reminder slip to give to patients.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.
- The practice were working with ASC colleagues and carers to support female patients with learning disabilities to understand the need and access breast screening, as they had identified they were a group of patients who did not routinely access screening programmes.
- The practice worked closely with The Bureau to launch social prescribing (community navigation) as a single point of contact to offer support to patients with their health and social needs. The Bureau held a drop in session and booked appointments at the practice on a weekly basis. The aim was to reduce repeat attendances and multiple GP appointments where the issues were social. Data provided by the practice showed 33 social referrals had been made by GPs as well as staff promoting the drop in sessions in the first nine months. Evaluation by The Bureau in November 2017 showed Manor House Hadfield were actively engaged in social prescribing and had referred patients for a range of support including mobility, anxiety/depression, loneliness and social isolation.
- The practice had walking group who regularly meet on Tuesdays. Patients from other practices within the locality were welcomed to join the group.
- There was a patient information room maintained by the PPG in the practice waiting area which included a wide range of health information and information about local services. There was also access to a resource library, computer, a blood pressure monitoring machine and weighing scales.
- The PPG with the support of the practice held health days for patients, most recently the held a mental health event with approximately 45 patients attending from both the practice locations.
- The practice has a Facebook page which they utilise for health promotion, for example Glossop park run, Leap 4 Life, e-cigarettes and child safety online.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.
- All clinical and non-clinical staff have completed Mental Capacity Act and DoLs training.

Good

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. Staff and the Patient Participation Group (PPG) had a number of initiatives to ensure equality and access to care and treatment, for example the practice were working towards the Pride in Practice award.
- The practice gave patients timely support and information and reception staff had undertaken patient advisor training to help direct patients appropriately and improve continuity of care.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 30 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients described the service they received as excellent and very good. They said the staff were professional, caring and friendly and often went the extra mile. Two patients told us it was sometime difficult to book double appointments and it was a nuisance getting prescriptions online, however all said the reception staff were friendly and helpful. The results of the NHS Friends and Family Test indicated patients were mostly 'extremely likely' and 'likely' to recommend the practice to their friends and family.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 366 surveys were sent out and 120 were returned. This represented about 1% of the practice population. The practice were in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 86% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 84% of patients who responded said the GP gave them enough time; CCG - 87%; national average - 86%.
- 93% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 90% of patients who responded said the nurse was good at listening to them; (CCG) - 94%; national average - 91%.
- 91% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 91% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 81% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average - 87%.

The PPG also carried out an annual patient survey across both the practice locations, the results from the 2017 survey were still being collated but we noted from the 2016 survey the following results:

- Of the 500 responses, 70 were patients at Manor House Hadfield.
- 95.2% say surgeries meet their diverse needs.
- 87% found the waiting area to be clean, light, airy, spacious, and bright with good information.

The PPG and practice produced and action plan for improvements following the survey which included changes to the appointment system to improve continuity of care and training for reception staff which we noted had been implemented.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.

Good

Are services caring?

- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. The practice wherever possible also ensured reviews and consultation for vulnerable patients were carried out by the same GP to establish a relationship and understanding of patients additional needs.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. This was supported by a suite of referral templates readily available to staff to easily refer patients for additional services and support in the community and secondary care.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer and a member of the reception team to liaise with carers and sent out carers information packs and kept information up to date in the waiting area. The practice had identified 2% of patients as carers. The practice had a dedicated carer's champion who regularly liaised with Derbyshire Carers Association (DCA) and we saw information for carers was readily available in the waiting area which was up to date and there was information on the practice website. DCA also routinely attend the practice, for example during the winter flu campaign they provided training for staff and awareness sessions for patients and assisted the practice in identifying carers and providing them with the relevant support and information carers need.

- Staff told us that if families had experienced bereavement, the GP best known to the family contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.
- For patients at the end of life the practice used Electronic Palliative Care Co-ordination Systems (EPaCCS) which places the patients' wishes at the centre of their care such as preferred place of death. EPaCCS enabled them to work together with other health and social care providers and out of hours services by sharing and having access to key information about patients ensuing coordinated joined up care for patients and their families.

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

- 82% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 88% and the national average of 86%.
- 78% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 82%; national average - 82%.
- 90% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 90% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Working with the PPG the practice looked at ways to improve confidentiality at the reception desk and installed a safety glass wall in the waiting area. The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours and seven day access via a local hub, online services such as repeat prescription requests, advanced booking of appointments, and advice services for common ailments.
- Extended appointments were available where required and the practice provided longer appointments for holistic long term condition reviews.
- The practice in 2017 introduced on call assist role for the HCA, the role aimed to improve patient experience and maximise the time GPs had during consultations by ensuring observations and tests were carried out and results available before the patient went in to see the GP.
- The practice had a text messaging facility in place where clinicians can text patients' results when expressed consent has been given. This facility was implemented in April 2017. Within 6 months of implementation, the method of text messaging results reduced the number of incoming calls from a baseline of approximately 2475 calls per month to an average of 1988 calls per month, therefore, freeing up reception staff to answer incoming calls to assist patients with other elements of care and treatment requests and improving the telephone system.
- The practice had also implemented a designated appointment cancellation line where patients could leave a message 24 hours per day to assist with appointment DNA rates and allowing the practice to offer the appointments to other patients.
- The practice worked closely with The Bureau (a voluntary organisation whose services included supporting people to stay physically and socially active, improve mental wellbeing and live independently for longer.) and referred patients but the Bureau also provided a weekly drop in and appointments at the practice for patients.
- The facilities and premises were appropriate for the services delivered.
- The practice initiated a minor injuries service with aim to provide the treatment direct to the presenting patient rather than referring on to the A&E for their management. Data provided by the practice showed of 77 patients treated under the scheme only 5 patients were sent to A&E, 45 were examined and given advice and 20 were sent direct for and x-ray.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice hosted an ultra sound and ECHO clinics and a dermatology specialist provided clinics at the practice providing care closer to home for patients. The practice was also able to offer a full contraceptive service and minor surgery at their other location close by.
- The practice and PPG were proactive in encouraging patients to sign up to have full online access to their medical records. In March 2016, the practice had 7% of patients registered for full online access to their medical records. We saw to date the practice had 18% of patients registered for full online access to their medical records.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment. The practice requested

Good

Are services responsive to people's needs?

(for example, to feedback?)

relevant blood tests were performed in advance to ensure all clinical information was available to complete reviews. The multi reviews were also provided for housebound patients within their own home. Consultation times were flexible to meet each patient's specific needs.

- To avoid hospital admissions the practice worked with community based services, including the community paramedic, urgent care team, children's community nursing team, heart failure nurses and community diabetic service.
- The PPG and practice worked together to put education events on for patients.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice was open from 7:15am one morning a week and were able to book evening and weekend appointments for patients at the local extended hours hub
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Local services such as ultra sound and dermatology were available at the surgery providing care closer to home. Minor surgery and a full contraceptive service were also available at their other location close by.
- The practice provided a facility via their surgery website for patients to email GPs, Advanced Practitioner Nurses and Practice Nurses with routine queries.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had an ethos of continuity of care for vulnerable patients and those with learning disabilities clinicians and reception staff were able to pre-book appointments and follow up visits to ensure wherever possible they would be seen by the same clinician.
- The practice provided GP cover to a local women's refuge and their safety was monitored and maintained, for example registration was to a PO Box registration.
- Work with the PPG and The Bureau the practice developed information sheets on how to access various groups and voluntary organisations to support those whom may be vulnerable, lonely or socially isolated.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice worked closely with the Derbyshire Trusted Befriending Network and the Alzheimer's society who provided dementia training to all staff to become a dementia friendly practice. They also helped guide the practice to make public areas more dementia friendly.
- For young people the practice referred to specialist services such as 42nd Street (youth support service), Healthy Young Minds and Glossop Social Services family centre.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The practice had recently audited there appointment system and revised it following feedback from staff, patients and the PPG. The new system supported by patient advisor training for reception staff had more provision for continuity of care and more pre-bookable appointments, initial evaluation of the new system showed less patients were having to call back the following day as they were able to pre book next day

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments, more patients were disclosing the reason for their appointment with reception staff enabling them to be direct more appropriately and more patents were able to see their GP of choice.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or below local and national averages. This was supported by observations on the day of inspection and completed comment cards. 366 surveys were sent out and 120 were returned. This represented about 1% of the practice population.

- 74% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 62% of patients who responded said they could get through easily to the practice by phone; CCG – 69%; national average - 71%.
- 74% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 82%; national average - 84%.
- 76% of patients who responded said their last appointment was convenient; CCG - 78%; national average - 81%.
- 66% of patients who responded described their experience of making an appointment as good; CCG - 69%; national average - 73%. The practice was looking to improve results and were encourage patients to utilise the online appointment system.

The practice used a range of methods to gather patient feedback which included internal surveys, questionnaires and the friends and family test. Feedback was monitored and reviewed thought out the year by the practice team and actions identified to make improvements. We noted from the friends and family test patients in the main were either 'likely' or 'extremely likely' to recommend the practice to friends and Family.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Two verbal and written complaints were received in the last year. We reviewed both complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.
- The practice shared feedback with the PPG from a variety of sources including complaints, suggestion box, friends and family survey, comments submitted via Healthwatch Derbyshire, Facebook, Google business and NHS choices. The PPG worked with the practice on improvements following feedback and produced "you say, we say" section in the practice newsletter where appropriate.
- The practice and PPG had close links with Healthwatch Derbyshire. They promote and encourage feedback via Healthwatch. Feedback was regularly received from patients via this method, discussed in practice meetings and responses together with learning were shared with Healthwatch.
- The PPG worked with the practice to devise a handout regarding NHS Choices for staff and clinicians to handout to patients to promote and encourage feedback via this method. We noted comments made to NHS choices were responded to.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice as outstanding for providing a well-led service.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. There was a strong culture of improving outcomes for patients across the practice and this was reflected in their aims and objective.
- Staff were aware of and involved in the development and monitoring of the vision, they understood the values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. For example one GP was the neighbourhood lead and we saw that some business proposals such as CRP testing in Practices was sought for the whole locality as well as for the practice.
- The practice planned its services to meet the needs of the practice population.

The practice monitored progress against delivery of the strategy and had a quality improvement programme in place.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients. We saw the staff, partners and PPG had a shared purpose, to deliver positive outcomes for patients and encourage self-care.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal, and career development conversations. All staff received regular annual appraisals and a timetable was in place for future appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice valued training and staff development both of internal staff but also mentoring and supporting both trainee GPs and nurses. We noted staff had been supported to achieve additional skills and qualifications for example the one practice nurse had recently gained advanced nurse practitioner qualification. A weekly peer support group was in place for trainees and the advanced nurse practitioner with one of the GP trainers to support learning and share knowledge. We also saw the practice had received three quality teaching awards for their work with trainee GPs
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Are services well-led?

Outstanding ☆

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

- There were positive relationships between staff and teams.
- The practice looked to award staff for their work and commitment to team work and patient care. Staff could nominate colleagues and certificates were awarded to staff to acknowledge there positive contribution.
- The practice worked closely with social care, community specialist paramedic, district nurses, Macmillan nurses, volunteer bureau and consultant colleagues and their teams in secondary care to support the effective assessment, care and treatment. We noted several examples of effective working relationships and positive outcomes for patients as a result of close joint working with others.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. Audits included Patients with borderline thyroid-stimulating hormone levels attended for repeat testing. The practice also audited the reception/access which resulted in changes to the appointment system and patient advisor training for staff.
- The practice had in place a process of continuous quality improvement and evaluation, led by a GP partner. We were provided with a range of quality improvement work. All quality improvement programmes had clearly defined aims and objectives, for example: End of life care and increasing the uptake of screening and immunisations. We noted they were on track to achieve the objective set in all areas of quality improvement such as reducing GP workload by analysing appointment requests received by the reception team and implementing care navigation (using Patient Advisor Training) to ensure the right care with the right person, freeing up five GP sessions between January 2016 and January 2017.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The practice participated in the local The Primary Care Quality Scheme and in 2016/17 they were the only practice locally to achieve 100% of indicators.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice had a range of methods to gather patient feedback. In addition to the National GP survey data, friends and family and responding to comments on NHS choices the PPG also carried out satisfaction surveys with patients on an annual basis, in the 2017 survey the

Are services well-led?

Outstanding ☆

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focused on the changes to reception and appointment system, results were still being analysed. The practice also carried out satisfaction surveys with patients for example, of the 26 completed family planning questionnaires in 2017, 96% rated the service overall as excellent. The practice also used the PPG to carry out evaluations, for example 'mystery shopper' customer service feedback on telephone answering and face to face interaction with the reception team.

- The practice kept a combined action log from the various methods of feedback which showed the action taken and outcomes in relation to patient feedback.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group (PPG) who met regularly holding formal and informal meeting on a monthly basis. The PPG were involved in a number of initiatives as well as seeking comments and suggestion from other patient they maintained the health information room within the waiting area, supported the practice in creating patient friendly letters, created a quarterly newsletter and set up education events for patients, the most recent example being in relation to mental health. Speaking with four members of the PPG they felt valued by the practice and able to make suggestions which the practice where possible would address any issues or concerns. They told us the practice used the PPG as a sounding board for changes, recent examples included changes to the reception and appointment system and confidentiality in the waiting area.
- Feedback from staff was gathered via regular meetings but the practice also conducted an anonymous staff survey and developed an action plan from the results which included recruiting an additional HCA to improve workload.
- The service was transparent, collaborative and open with stakeholders about performance. Partners and managers were active members of the locality group where they shared learning and new initiatives with colleagues.
- The practice website was well maintained and contained not only information about the service provided also a range of self care and health promotion information with links to local and national support organisations.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example:

- The continued quality improvement programme which engaged staff at all levels
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice continued to embrace new tools and technology to improve outcomes for patients such as developing the end of life care tool and be more localised and using C-reactive Protein (CRP) tests prior to prescribing antibiotics.
- The practice were working with Tameside and Glossop Integrated Care Foundation Trust to pilot utilising technology to be able to seek opinions, advice and guidance securely from peers and other clinicians who may have specialisms for example cardiology advice and guidance, rheumatology advice and guidance and paediatric advice and guidance via electronic referral (e-RS).

Are services well-led?

Outstanding ☆

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

- The practice was also taking part in the Greater Manchester wide Atrial Fibrillation (AF) initiative which started in November 2017.
- They practice were are committed to working in partnership with social care and voluntary organisations to support patients social as well as physical and emotional well-being and continue to be practice in social prescribing.