Lupset Health Centre

Quality Report

George A Green Court
Wakefield
West Yorkshire
WF2 8FE
Tel: 01924 668977
Website: www.lupsetsurgery.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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall.

The practice had been previously inspected on 22 September 2015 when it was rated as Good overall, with one domain being rated Requires Improvement for the provision of responsive services.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Good

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

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Lupset Health Centre on 15 November 2017. The inspection was carried out as part of our inspection programme and was also used to follow up areas where at the time of the last inspection, on 22 September 2015, the provider was informed they should take action to improve some areas in respect of the provision of responsive services. This included improving access to the practice for patients with a disability, improving the ease of patients contacting the practice by telephone, and the need to provide patients with access to information about how to make a complaint. We noted at the 15 November 2017 inspection that the practice had taken action to improve these service areas.

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.
- A number of higher level services were provided within the practice which would otherwise be usually delivered in secondary care settings.
- The practice showed better than average performance in relation to the prescribing of antibiotic items.

Summary of findings

- The practice offered home visits from 9am, which supported provision of earlier interventions, and prevented deterioration and possible admission to secondary care services. Urgent care was also prioritised with appointments being available for these patients on the day of presentation.
- Staff discussed treatment options with patients, and we were told by carers and patients that they were treated with compassion, kindness, dignity and respect by all the staff in the practice.
- The practice provided services to patients who were assessed as being potentially violent and had been excluded from mainstream GP services.
- Public engagement was positive and active. The practice sought patient feedback via a number of routes, such as carrying out individual surveys and engagement with the established Patient Participation Group. The practice was responsive to patient feedback and had implemented improvements to the practice telephone system in light of previous low patient satisfaction.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw two areas of outstanding practice:

- The practice recognised there was high local patient demand for mental health services (including those for dementia). In response to this it had employed a mental health nurse and delivered a number of dedicated services to meet these needs.
- The practice provided services to patients who had been assessed as being potentially violent, and had therefore been excluded from accessing services provided by their own GP practice. As well as having delivered care to these patients, over time Lupset Health Centre had supported a significant number to return to other mainstream GP services.

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

Lupset Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Lupset Health Centre

Lupset Health Centre is situated within a purpose built surgery located at George A Green Court, Wakefield, West Yorkshire, WF2 8FE. The practice provides services for approximately 14,100 patients and is part of the NHS Wakefield Clinical Commissioning Group (CCG).

The practice is located over two floors and is accessible for those with a physical disability; as floor surfaces are level, entrance doors are automatic and wide allowing access for patients using wheelchairs. Consulting and treatment rooms are all located on the ground floor with the upper floor used for administration, meeting and educational purposes. There is parking available on the site for patients, and a privately operated pharmacy is located adjacent to the practice building.

The practice population age profile shows that it is slightly above the CCG and England averages for those under 18 years old (23% compared to the CCG average of 20% and England average of 21%). Average life expectancy for the practice population is 78 years for males and 81 years for females (England average is 79 years for males and 83 years for females). Information published by Public Health England rates the level of deprivation within the practice population group as three on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice population is mainly White British in composition.

The practice provides services under the terms of the Personal Medical Services (PMS) contract. In addition the practice offers a range of other services including those in relation to:

- Childhood vaccination and immunisation
- Influenza and Pneumococcal immunisation
- Meningitis immunisation including catch up services for young people
- Yellow Fever
- Rotavirus and Shingles immunisation
- Extended hours access
- Dementia support
- Learning disability support
- Minor surgery
- Patient participation
- Services for violent patients and patients who have been excluded from other practices

Attached to the practice or closely working with the practice is a team of community health professionals that includes health visitors, midwives and members of the district nursing team.

There are five GP partners (four male, one female), five salaried GPs (all female) and one GP Registrar (female). There are two nurse practitioners (one male, one female), five practice nurses (all female), one mental health nurse

Detailed findings

(female), four health care assistants (all female) and one phlebotomist (female). Supporting these clinicians is a reception and administration team led by a practice manager.

The practice reception is open for enquiries and surgeries operate daily from 8am to 6.30pm. Pre-booked appointments for early and late surgeries are available from 7.30am on Monday, Tuesday, Wednesday and Friday and until 8.45pm on Monday and Thursday. The reception is manned during these early and late surgeries. The practice had an online presence www.lupsetsurgery.co.uk, and offered services including online appointment booking, ordering repeat prescriptions and limited information from medical records.

Extended and out of hours services are provided by GP Care Wakefield and patients can access these via the practice telephone number.

This practice has been accredited as a GP training practice supporting doctors training to specialise in General Practice, and also provides placements for student nurses.

The inspection rating relating to the previous inspection was on display within the building and was posted on the practice website.

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 comprehensive suite of safety policies which were regularly reviewed and accessible to staff on the practice computer system. Issues in relation to health and safety were also discussed at team meetings. We saw that staff received safety information concerning the practice as part of their induction; which was refreshed when appropriate. The practice had systems to safeguard children and vulnerable adults from abuse. Policies regarding safeguarding were regularly reviewed and were accessible to all staff. These policies and supporting procedures outlined clearly who to go to for further guidance. The practice had appointed a GP with lead responsibility for, and oversight of, safeguarding. A deputy to the safeguarding lead had been appointed to cover times of absence.
- 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 practice carried out staff checks, these included checks of professional registration on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken when 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 (a chaperone is a person who serves as a witness for both a patient and a medical professional as a safeguard for both parties during an intimate medical examination or procedure).
- There was an effective system to manage infection prevention and control (IPC). The practice had been subject to a recent IPC audit within the last 12 months which showed they had achieved a score of 94%.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing and disposing of 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, and the practice actively managed capacity issues as they developed. The practice told us that they rarely needed to use locum and agency staff due to effective staff planning and flexibility within the workforce.
- There was an effective induction system for temporary staff specifically tailored to their role. Records of induction were kept on staff personnel files.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff knew how to identify patients with severe infections, such as sepsis, and clinicians knew how to effectively manage those conditions.
- When there were changes to services or staff the practice assessed, monitored and managed possible impacts on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, the practice could share information regarding patients via their computer system and through both formal and informal meetings.

Good

Are services safe?

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 taken actions to support the effective management of the use of antimicrobial products, this included raising staff awareness of the issue and actively monitoring and reporting on prescribing rates.
- 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.

- We saw there were comprehensive risk assessments in relation to safety issues and that these were regularly reviewed.
- The practice monitored and analysed activity and looked for any emerging trends. This helped it to understand risks and gave a clear, accurate and current picture. The practice management team told us, and staff confirmed this, that the practice had a no blame culture and saw learning from incidents as an opportunity to improve systems and prevent recurrence.

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.
- We saw evidence to show that there were 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. For example, the practice had identified that an incorrect address on their computer system had meant that opportunities for patient reviews had been missed. The practice had tracked the source of the incorrect address and rectified this with the external body responsible.
- There was a system for receiving, assessing and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. One of the practice GPs was the deputy clinical chair of the local CCG and used their experience with this role to further improve services within the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all 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 practice showed better than average performance in relation to the prescribing of antibiotic items that are Cephalosporin's or Quinolone's (those are broad spectrum antibiotics which can be used to treat resistant infections). The practice had only prescribed 2% of these compared to a CCG average of 3% and a national average of 5%. The practice told us this had been achieved by improving awareness with clinicians and educating patients regarding the appropriate use of antibiotics.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice staff utilised a laptop during home visits which ensured prescribing, referrals and secondary care interfaces were recorded during the visit. The practice felt that this saved time and reduced duplication of effort, but also improved the accuracy and quality of consultation records.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice undertook home visits from 9am. The practice told us that they felt this had a positive impact on patients, by providing earlier intervention and preventing deterioration and possible admission to secondary care services. Urgent care was also prioritised with appointments being available for these patients on the day.

Older people:

- An advanced nurse practitioner (ANP) carried out home visits for housebound elderly or infirm patients. This included the fortnightly care visits to support 25 to 30 patients in a residential and nursing home setting. The practice reported that since moving to this way of working that there had been significantly better liaison and working with care home staff, and that continuity of care had improved. During the second quarter of 2017 the ANP had delivered 259 episodes of individual care at the residential and nursing home. In addition the practice carried out regular palliative end of life care sessions to the home. This service was delivered by a GP, in conjunction with the ANP. This ensured the often complex needs of patients in this area were met and that there were minimal delays in death certification. During the second quarter of 2017, the GP had delivered 90 individual episodes of care to residents.
- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail or at risk received clinical reviews which included a review of medication.
- Patients aged over 75 were invited for a health checks and reviews. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were reviewed and updated to reflect any extra or changed needs.

People with long-term conditions:

- The practice employed two specialist diabetic nurses and offered advanced diabetic care services; which included insulin initiation. Since 1 April 2017 the practice had initiated five patients on to insulin, and since 1 January 2017 had initiated nine patients on to GLP-1(GLP-1 is a class of injected drugs used for the treatment of type 2 diabetes).
- The practice worked closely with secondary care partners and delivered a joint diabetes clinic for those with more complex needs. These clinics were held at the practice on a quarterly basis. From March 2017 to November 2017, 30 patients had attended this service which was delivered by the practice senior diabetic nurse and a specialist diabetic nurse from secondary care. The practice also carried out quarterly case reviews of complex diabetic patients which was held

Good

Are services effective?

(for example, treatment is effective)

with a secondary care specialist consultant, the practice lead GP for diabetes and at least one of the practice diabetes nurses. Approximately 15 to 20 patients were discussed at each review meeting.

- The practice had conducted a pre-diabetes case identification; this had identified over 400 patients at risk of developing the condition. The practice had worked with the local public health team to support this cohort in a bid to them stop developing diabetes in the future.
- Overall performance in relation to the treatment of patients with long term conditions was generally either comparable to, or above other practices both locally and nationally. It did however show below average performance in relation to some areas, these included:
  - 75% of patients with asthma, on the register, had received an asthma review in the preceding 12 months that includes an assessment of asthma control compared to a CCG average of 81% and a national average of 76%.
  - 82% of patients with cancer, diagnosed within the preceding 15 months, had a patient review recorded as occurring within 6 months of the date of diagnosis compared to a local CCG and national average of 94%.

We discussed these areas of underperformance with the practice and they told us that these results could be linked to the behaviours of the practice population demographic and to low case numbers. They said that they would investigate this further.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.

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

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice's uptake for cervical screening was 81% which was slightly above the 80% coverage target for the national screening programme.
- Patients had access to appropriate health assessments and checks. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. During the second quarter of 2017 the practice had carried out:
  - 112 NHS health checks (for patients 40 to 74 years old)
  - 161 new patient health checks (for new patients over ten years old)
  - 14 learning disability health checks (for patients with a learning disability who were aged over 14 years old)

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. For example, the practice carried out a weekly palliative/end of life visit to a large local residential and nursing home care provider.
- Palliative care was discussed at monthly multi-disciplinary team meetings. Patients were prioritised for support and services according to need.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability, and the frail elderly with complex needs.

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

- 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was above the CCG average of 92% and the national average of 90%.
- The percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 93% which was above the CCG average of 92% and the national average of 91%.
- There was a high prevalence of mental health issues in the locality; for example 2,680 patients from the practice had a diagnosis of depression. In recognition of this local need the practice had taken steps to provide specific support for patients with poor mental health and those living with dementia. For example:

Good

Are services effective?

(for example, treatment is effective)

- The practice employed a dedicated mental health nurse. We were told by the practice that this had led to improvements in the quality of mental health services (such as information contained in Do Not Attempt Resuscitation forms) and in the capacity to deliver mental health care. During the second quarter of 2017 the mental health nurse had delivered:
  - 172 dementia clinic appointments for 65 patients with dementia
  - 405 mental health appointments for 85 patients with dementia
  - 19 learning disability appointments for 19 patients with a learning disability.
- The mental health nurse had worked closely with the CCG learning disabilities advisor to carry out health care reviews.

- A recent review of learning disability patients had been carried out to ensure that the correct diagnosis had been captured.

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. We examined in detail five clinical audits that had been carried out within the last year. We saw that these had led to either developments within the practice or assured the practice that operating standards were being met. Three of these audits were completed two cycle; audits where improvements made were implemented, monitored and assessed for further action. For example, an audit into care plans carried out in February 2017 saw improved performance compared to a previous audit but identified a continued need to improve the level of information captured on the care plan record template. We saw that audits were shared across the practice.

The practice participated in local and national improvement initiatives. For example, it had participated in the previous Prime Minister's Challenge Fund and then the subsequent Vanguard programme (a programme to improve local health and integrated care services). Through this the practice had:

- Delivered dedicated services to patients in care home settings including routine health visits.
- Enhanced health and care signposting, referral and information for patients using care navigators to other services which were not specifically those offered by GPs or nurses, such as pharmacists and physiotherapists.
- Utilised the services of pharmacists and physiotherapists whowere based within the practice to deliver care, which included:
  - Pharmacists who carried out medication reviews, answered medication queries and issues related to discharge medication.From 1 January 2017 1,398 patients were navigated to the pharmacist which saved on average 30 GP/nurse appointments each week.
  - Referral to the in-practice physiotherapy service which provided four 15 minute assessment appointments three days a week. In addition patients with sudden onset musculoskeletal pain were directed to the service. From 1 January 2017, 54 patients had used the service which saved an average of two GP appointments per week.

The most recent published Quality Outcome Framework (QOF) results for 2016/17 showed that the practice had achieved 95% of the total number of points available compared with the clinical commissioning group (CCG) and national average of 96%. The overall exception reporting rate for the practice was 6% which was below the local CCG average of 9% and the 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.)

We discussed with the practice where their QOF performance was below either the local or national averages. They told us that they proactively monitored performance and sought when necessary to implement actions to improve. For example:

- Performance linked to reviews – the practice had formulated a new approach to inviting patients for reviews. They intended to invite patients for reviews

Good

Are services effective?

(for example, treatment is effective)

during their month of birth to reduce any year-end backlogs of reviews. In addition the practice were seeking to capture patients for reviews who had attended the practice for other services such as for flu vaccinations.

- A specific audit had been carried out into cancer reviews and a new process had been subsequently introduced to ensure that the maximum number of patients received a review.
- Reminders were placed on patient records to remind clinicians of any outstanding actions required and to increase uptake of reviews/health checks.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop and there was evidence of career progression within the practice.
- 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 practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making and performance against national standards.
- The practice outlined how they had a clear approach for supporting and managing staff when their performance was below the required standard 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.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. For example, the practice had undertaken a patient pre-diabetes case identification which had identified over 400 patients at risk of developing the condition. The practice had worked with the local public health team to support this cohort in a bid to them stop developing diabetes in the future.
- The practice was comparable to other practices in 2015/16 for new cancer cases who were referred using the urgent two week wait referral pathway.
- 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. As an example, the Patient Participation Group (PPG) had worked within the practice to raise cancer awareness. Activities to date had included distributing around 200 bowel cancer screening cards within the practice, and distributing another 100 via a separate community organisation. Staff also signposted staff to other cancer support groups locally.

Consent to care and treatment

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

Good

Are services effective?

(for example, treatment is effective)

- 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.
- The practice leaflet raised patient awareness of consent issues.

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, and social and needs.
- The practice gave patients timely support and information. The waiting room had a large number of leaflets and other information which included an electronic health and social care advice point. Both the practice leaflet and website was comprehensive and also offered details of other support organisations. Staff had been trained in care navigation and were able to give patients details of treatment options available to them.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.
- We received 13 patient Care Quality Commission comment cards. These were all positive about the service they experienced. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. As part of the survey 242 survey forms were sent out and 101 were returned for a response rate of 42%. This represented less than 1% of the practice population. The practice was generally above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 81% of patients who responded said the GP gave them enough time compared to a CCG average of 85%and the national average of 86%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw compared to CCG and national averages of 95%.
- 90% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 86%.
- 95% of patients who responded said the nurse was good at listening to them compared to a (CCG) average of 92% and a national average of 91%.
- 96% of patients who responded said the nurse gave them enough time compared to a CCG average of 93% and a national average of 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw compared to CCG and national averages of 97%.
- 94% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; compared to the CCG and national averages of 91%.
- 88% of patients who responded said they found the receptionists at the practice helpful compared to a CCG average of 86% and a national average of 87%.

The practice had a proactive approach to the receipt of patient feedback. For example it examined results from the national GP patient survey and other sources such as NHS Choices and looked at ways to improve performance. In addition the practice had commissioned their own patient user feedback for specific services; such as a 2017 survey of patients who had accessed minor surgery. Results from this survey showed generally high patient satisfaction with the service.

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 and translation services were available for patients who did not have English as a first language, and two hearing loops were available for patients who had a hearing impairment.

Good

Are services caring?

- We were told by patients that staff communicated with them in a way that they could understand.
- 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.

The practice proactively identified patients who were carers. This was achieved at patient registration, opportunistically during consultations and was regularly raised during key events held in the year such as at flu vaccination sessions. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 240 patients as carers (around 2% of the practice list). Identified carers were able to access enhanced health support from the practice as well as being signposted to other services should this be required. On the day of inspection we spoke with a patient and their carer who were both very positive with regard to the services they received from the practice.

Staff told us that if families had experienced bereavement, the practice would contact them and offer their sympathy and support. This support could be 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.

Results from the national GP patient survey showed patients generally 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:

- 86% 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 84% 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 compared to the CCG average of 80% and the national average of 82%.
- 91% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared to CCG and national averages of 90%.
- 88% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998. As part of this the practice operated an end of day/work session clear desk policy.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

The practice was rated as outstanding for providing responsive services because:

- There was evidence of effective patient engagement via the Patient Participation Group, internal service user surveys, and direct consultation which included discussions with youth groups and local schools.
- Early day home visits were provided with the aim to prevent the possible deterioration of a patient's condition.
- The practice provided a number of dedicated or enhanced services to meet the needs of patients with complex needs.
- There was a focus on working with partner organisations and stakeholders to improve the health and wellbeing of patients.
- The practice provided services for potentially violent patients who had been excluded from other mainstream GP services.

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice offered extended opening hours and employed a dedicated mental health nurse and diabetic nurses to meet the specific needs of the local population.
- The facilities and premises were appropriate for the services delivered.
- 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.
- Patients could access telephone consultations with GPs.
- The practice operated a triage doctor and duty doctor system which improved patient assessment of patients and responsive service delivery of care.

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 in supported living.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. In addition the practice made planned, proactive visits to patients in a local residential and nursing home setting.

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.
- The practice had a nurse whose role was to support patients who have more than one long term condition. By utilising this service patients could access multi-condition reviews and received coordinated care appropriate to their needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The practice had actively participated and supported a recent CCG led survey for post-natal services (results of which were still awaited).
- The practice had gained local accreditation for the provision of services to children and young people. It had taken positive steps to improve services for young people; such as the recruitment of a male nurse practitioner and the encouragement of school age males to attend clinics run by him.
- Staff from the practice had visited local community schools and youth groups to promote health and social care awareness and also to canvas the views of young people on health matters.
- We found there were systems to identify and follow up children living in disadvantaged circumstances.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Parents or guardians who called with concerns about acutely unwell babies and young children could obtain urgent same day appointments.
- Appointments were available outside of school hours both early and late in the day.
- The practice offered a comprehensive family planning service which included longThe practice participated in the C-Card scheme which gave young people access to free contraceptives.

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, early and late appointments were available to patients, and through partnership working arrangements patients could access GP appointments outside regular working hours.
- The practice offered online services for appointment booking, ordering repeat prescriptions and limited information from medical records.
- Working with the Department of Work and Pensions, the practice hosted a community work coach, who saw and supported patients who were either at risk of losing their job or who had lost their job through ill health. Since March 2017 the work coach had a total of 63 patient appointments. Outcomes have included:
  - Supporting patients into adult education
  - Supporting job applications and patients returning to work after absence

The practice told us that since this initiative began the numbers of both fit notes issued and GP appointments for these patients had decreased.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances with a learning disability, patients with other disabilities and the frail elderly with complex needs.
- Whilst the practice had a 'did not attend' policy (which covered the practice's approach to patients who regularly did not attend appointments), they told us that they were tolerant of missed appointments by vulnerable patients or those who had specific issues which prevented their attending appointments.
- Since 2008 the practice had provided care services to patients who were seen as potentially violent and aggressive and had been excluded from practices previously. Since this time the health centre had met the needs of these 85 patients as part of the Safe Haven violent patient scheme. Of these patients 44 had subsequently been supported by the practice to return to other mainstream GP services.

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

- The practice recognised high local patient demand for mental health services. In response to this it had employed a mental health nurse and delivered a number of dedicated services to meet these needs.
- The practice was a member of Wakefield Council's Safer Places Scheme. This provided a safe haven for those within the community that were vulnerable and who may need help and assistance outside their home environment.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Dementia awareness raising had taken place for staff and PPG members.
- The practice planned to host a dementia "pop-up" clinic operated by Alzheimer's UK. The initial clinic was to have eight 30 minute sessions, and at the time of inspection six of these had already been booked. The clinic was to offer specific tailored advice to patients, their families and carers.
- The practice was dementia friendly and had accessed funding which had enabled them to make improvements which included:
  - Installing colour contrasted toilet seats
  - Improving signage
  - Fitting dementia clocks in the waiting room and the room where dementia reviews were held

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Patients on the mental health register received 30 minute appointments with the dedicated mental health nurse.

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 appointment system was easy to use and patients had options in relation as to how they could book appointments.

Results from the July 2017 national GP patient survey showed that patients' satisfaction with how they could access care and treatment was generally comparable to local and national averages. A number of patients had however responded negatively that compared to other practices they could not get through easily to the practice by phone, and that they sometimes had to wait too long to be seen. This view was supported by two comment cards which raised issues in relation to contacting the practice. Out of the 242 surveys that were sent out, 101 were returned. This represented less than 1% of the practice population.

- 77% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 54% of patients who responded said they could get through easily to the practice by phone compared to a CCG average of 65% and a national average 71%.
- 82% 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 compared to a CCG average of 82% and the national average of 84%.
- 82% of patients who responded said their last appointment was convenient compared to a CCG average of 80% and a national average of 81%.
- 72% of patients who responded described their experience of making an appointment as good compared to a CCG average of 68% and a national average of 73%.
- 54% of patients who responded said they don't normally have to wait too long to be seen compared to a CCG average of 60% and a national average off 58%.

We discussed the lower than average patient satisfaction in relation to patient telephone access. The practice explained to us that they had investigated this in detail and had put in place a number of measures to improve this, these included:

- Increased the number of telephone lines
- Organised additional staffing of telephone lines
- Redesigned the telephone options menu with PPG input
- Provided additional appointments to cope with demand from calls
- The introduction of care navigation
- Raising awareness amongst patients of how to best use the telephone and appointment systems

Since the introduction of these measures we received feedback from patients which showed that access had improved.

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 complaints policy and procedures were in line with recognised guidance. The practice had received nine complaints from April 2017 to November 2017. We reviewed these complaints and found that they were satisfactorily handled in a timely way.
- The practice investigated complaints thoroughly and used a detailed proforma/action plan to manage the process, in particular the practice sought to learn lessons from individual concerns and complaints and

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

identify opportunities to improve or redesign services. We saw that the practice also analysed complaints to identify any emerging trends. The last analysis of complaints had not identified any specific trends.

- Complaints were shared with both staff and members of the PPG to identify learning opportunities and possible solutions to raised concerns.

Are services well-led?

Good

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

Our findings

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

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy 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.
- We were told by staff that 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. For example, the practice sought to tackle issues in relation to staffing and succession planning and had implemented effective career development routes for staff within the workplace.

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 approach and supporting strategies and plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. Staff we spoke to were very clear that they wanted to deliver the best care possible to their patients.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- Their approach was in line with health and social priorities across the local area, and the practice planned its services to meet the needs of the practice population.
- The practice had monitoring systems and processes in place to assess performance against delivery of their strategic approach.

Culture

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

- Staff stated they felt respected, supported and valued. They told us that they were proud to work in the practice.
- The practice focused on the needs of patients and had introduced a number of services such as the specialised diabetes clinic to meet these needs.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We saw evidence that the practice had communicated openly and frankly with a patient who had been subject to a delay in their referral to an external service. 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. This was supported by the approach of leaders and managers who told us that the practice had a blame-free culture and sought to maximise learning from incidents and complaints.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff had received regular annual appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- 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. In addition we were told by staff that relationships within the practice were strengthened by activities such as team building and social events.

Are services well-led?

Good

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

- 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.
- The practice had introduced a monthly staff recognition award which sought to highlight staff who had shown exceptional performance. We were told this was often in relation to staff showing an "above and beyond" caring attitude to patients.

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 compliance against national guidance. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. This included a business continuity plan which was available to all staff on the practice IT system, and additionally in hard copy format by leaders and managers.
- 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 such as via surveys of patients who had received specific services.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The information used to monitor performance and the delivery of quality care was accurate and useful. The practice analysed performance issues and we saw that when identified plans were put in place to address them.
- 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. For example, from patient feedback the practice had identified that patient access via the telephone was low.

Are services well-led?

Good

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

They had worked with others including the Patient Participation Group (PPG) to put in place effective measures to improve this. Actions included additional telephone lines and staff answering them, and raising the awareness of patients as to how to book appointments.

- The PPG told us that they felt listened to by the practice and they felt a valued stakeholder. As well as patient engagement the PPG was heavily involved in supporting service improvement. This included services for patients with dementia. They had recently made a donation to a local secondary care provider from fundraising activities carried out within the practice to support people with dementia.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice made use of in-house, local and national surveys to improve performance.We saw evidence, which included some from an external organisation, that the practice had an open and collaborative approach to gathering and acting on patient feedback.

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. For example, the practice analysed complaints and concerns raised and used learning from these incidents to redesign and improve services.
- Staff knew about improvement methods and had the skills to use them.
- Leaders and managers encouraged and supported staff to review individual and team objectives, processes and performance.