Elmwood Family Doctors

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Elmwood Health Centre on 12 August 2015. Overall the practice is rated as good.

Our key findings were as follows:

- Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day.
- Patients' needs were assessed and managed. Care was planned and delivered following best practice guidance.
- Patients told us they were treated with kindness, warmth, compassion and respect by staff.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- There was a clear leadership structure and staff felt supported by the management and GP partners.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded and addressed.

However, there were areas of practice where the provider needs to make improvements.

Importantly, the provider should:

- Ensure a health and safety risk assessment for the premises is completed and an action plan implemented in accordance with the findings.
- Ensure where the decision has been made not to carry out a DBS check for non-clinical staff who act as chaperones, there is a written risk assessment in place.
- Ensure all staff are aware of the practices business continuity plans.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. A health and safety risk assessment for the premises had not been completed to identify any risks or areas for improvement. Where the decision had been made not to carry out a DBS check on non-clinical staff who acted as chaperones, there was no written risk assessment in place. Staff were knowledgeable of actions to take in the event of a major incident, such as power failure or building damage. However they were unaware of the practices business continuity plans.

However, there were enough staff to keep patients safe. Staff generally understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. The practice manager had identified further training on completing incident forms was needed for all staff. Lessons were learned and communicated to support improvement. Risks to patients were assessed and well managed. The practice had a low turnover of staff and there was a good level of support within the team. However, the practice should ensure a health and safety risk assessment for the premises is completed and an action plan implemented in accordance with the findings.

Are services effective?

Good

The practice is rated as good for providing effective services. There were good processes in place for the practice to monitor its performance. National data such as the Quality and Outcomes Frame work (QOF) showed the practice performed well in all areas. The most recent data showed the practice had achieved 99.1% of the available QOF points.

Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their role and any further training needs had been identified and appropriate training planned to meet these needs.

There was a wide range of additional clinics and services available for patients within the practice. There were good services in place specifically for older people and those patients who had a learning

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disability. The practice had close links with a local home for adults who had severe learning disabilities and had significant care needs. All the patients who resided at the home were registered with the practice and they had a named GP.

Staff worked with multidisciplinary teams to provide effective care and support to patients, improve outcomes and share best practice. GP partners had developed streamlined care pathway templates, for example palliative care templates to ensure patients with the condition followed the same pathway. This enabled GPs to quickly access information and spend more time with patients during their appointments.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Patients spoke highly of the care they received from the practice. Feedback about patients' care and treatment was consistently positive. We observed a patient centred culture.

We saw services were provided to support people to cope with their care and treatment. The practice provided patients with an in-house bereavement service. The GP partners were passionate, motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. The GP partners told us that they always undertook bereavement visits.

The practice provided an in-house alcohol prevention service to patients. Two GPs had received training from the Royal College of General Practitioners (RCGP) in the management of alcohol problems in primary care. The GPs supported the specialist (alcohol prevention) nurses to provide weekly appointments to patients.

Information to help patients understand the services was available and easy to understand. Views of external stakeholders, for example Greater Huddersfield CCG were very positive and aligned to our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were specifically for older people and those patients who had a learning disability. The practice had developed a comprehensive and innovative system to monitor appointments using an automatic spreadsheet with a formula that gave a visual representation of

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whether the practice had sufficient staff capacity. There was continuity of care and urgent appointments available on the same day. Patients said they found it easy to make an appointment and urgent appointments were available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available on the website and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff. They acted on suggestions for improvements and changed the way they delivered services in response to feedback from the friends and family test and also the patient participation group (PPG).

The practice linked in with other local providers to improve outcomes for patients. For example, the practice undertook 'mini ward rounds' in a local disabled young adult residential home to provide additional health care and support.

The practice demonstrated good and improved access to sexual health services for young people. They had developed good working relationships with local residential care homes where they had registered patients. The practice had a daily designated duty doctor to ensure patients could quickly access urgent appointments. Residents in a local disabled young adult residential home had a named GP to ensure continuity of care. A named GP visited the home on fortnightly and on a needs basis to undertake 'mini ward rounds'.

One of the GPs was a board member of Greater Huddersfield CCG which enabled them to have a good working knowledge of the local area. The practice reviewed the needs of its local population and engaged with the CCG to secure/improve service improvements where these had been identified. The practice had been involved in CCG pilots, such as pathfinder, winter access and breaking the cycle. Learning from complaints was shared with staff, patients and the PPG.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision with quality and patient safety as its priority. The practice ethos was to deliver the best quality of care to everyone. They told us having a motivated team of staff enabled them to deliver good care to patients. The strategy to deliver this vision was discussed with staff. High standards were promoted and owned by the GP partners and was shared with staff.

All staff had clearly defined roles, responsibilities and expectations. The practice carried out proactive succession planning. They told us that they preferred to be over doctored to have a higher GP to

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patient ratio. The practice proactively used audits to influence change in guidelines to ensure quality control. The practice gathered feedback from patients and it had an active PPG which influenced practice development. It worked with patients and the local community in a collaborative way to improve services and they were continually looking to improve services using information technology.

The practice had a number of policies and procedures in place. The practice communicated effectively with staff, the PPG and with stakeholders through a range of meetings, including multi-disciplinary, safeguarding, medicines management, PPG, case conferences, clinical meetings, administrative meeting, practice protected time (PPT) events and daily coffee meetings. There were systems in place to monitor and improve quality and identify risk. Staff received an induction, regular performance reviews and they felt supported by the 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

Good

The practice is rated as good in providing responsive, caring, effective and well led care of older people. They offered a proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example, avoidance of unplanned admissions which they have effectively implemented over the last 12 months working in conjunction with community matrons.

The practice worked closely with the residential homes and offered weekly visits, telephone guidance and advice to support the residents. All patient and residents at the homes had a named GP to undertake regular reviews and to ensure continuity of care. This enabled the named GPs to develop working relationships with family members/carers as well as to identify any safeguarding concerns.

The practice had participated in the Polypharmacy (this is the use of four or more medications by a patient, generally adults aged over 65 years) review initiative by Greater Huddersfield Clinical Commissioning Group (CCG) to ensure safe and effective prescribing to older patients. It had a palliative care lead GP who held regular Gold Standard Framework meetings to ensure good communication between team members looking after palliative care patients, as well as a forum for multi-disciplinary learning.

The practice worked very closely with other health professionals and community and voluntary services and they were focused on using every opportunity for health promotion. For example, Friend to Friend and Sharing Memories.

People with long term conditions

Good

The practice is rated as good for providing effective, responsive, caring and well led care of people with long term conditions. Regular clinical and NICE updates were accessible to staff and practice protocols were reviewed in accordance with the guidelines. There was a robust and comprehensive recall system for patients with long term conditions to ensure they received routine checks as well as medication reviews. Patients had a named GP to ensure continuity of care and to empower the GP as the patient advocate. The practice provided a local anticoagulation clinic for patients. They supported patients with educational material, expert patient

Summary of findings

programmes and appropriate referrals were made to both NHS and voluntary services. The practice sign-posted patients to support groups and courses using promotional material such as health promotional TV screens and social media.

Families, children and young people

Good

The practice is rated as good for providing responsive, effective, caring and well led care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Monthly multi-disciplinary safeguarding meetings were held at the practice to discuss any concerns.

A full range of contraceptive services were offered to patients. The practice had strong links with local schools and worked collaboratively with the school nurses to support and advise young people. Young people at schools had direct access to same day appointments for emergency contraception, when the school nurse may accompany the patient. In addition, the practice worked collaboratively with the local pharmacy to dispense the emergency pill from the practice to preclude the need for patients to visit the chemist. There was a patient confidentiality policy in place and staff were knowledgeable to assess Gillick competence for young people. There were effective communication using electronic patient records between clinician's and other appropriate community teams

Appointments were available outside of school hours and the premises were suitable for children and babies. The practice told us all young children were prioritised, urgent appointments were managed through telephone triage.

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing responsive, caring, effective and well led care of working age people (including those recently retired and students). The practice had extended hours, including pre-bookable appointments and telephone appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. There was equal access to students as temporary residents compared with registered patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for providing responsive, effective, caring and well led care of people whose circumstances may make them vulnerable. They offered proactive, personalised care to meet

the needs of this population group and had a range of enhanced service such as learning disabilities, alcohol and remote care monitoring. The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

Residents in a local disabled young adult residential home had a named GP to ensure continuity of care. A named GP visited the home on fortnightly and on a needs basis to undertake 'mini ward rounds'. In addition the GP had annual meetings with the families of the residents. It carried out annual health checks and offered longer appointments for people with a learning disability. Patient status alerts were used within the clinical system to make staff aware when they are dealing with a vulnerable patient.

The practice offered a range services for example, anticoagulation, smoking cessation and alcohol reduction clinics to offer care closer to patients' homes, within a rural community which benefited older patients and those with reduced mobility. The practice provided an in-house alcohol prevention service to patients. Two GPs had received training from the Royal College of General Practitioners (RCGP) in the management of alcohol problems in primary care. The GPs supported the specialist (alcohol prevention) nurses to provide weekly appointments to patients.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and

how to contact relevant agencies in normal working hours and out of hours. Any patients who were identified as being vulnerable, including looked after children and people, who were homeless, were coded on the practice computer system.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for providing responsive, effective, caring and well led care of people experiencing poor mental health, including people living with dementia. Although the practice was not contracted to provide an enhanced service for facilitating timely diagnosis and support for people with dementia, we saw evidence that an enhanced level of service provision was provided above what is required under core General Medical Service (GMS) contracts. Patients had a named GP to ensure continuity.

Patients had support from a health trainer who worked in collaboration with Kirklees Council. In addition there was a carers champion and the practice were in the process of developing a carer's register. Patients had medication reviews and targeted health

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checks. In additions, the practice had a robust recall system to ensure the medication reviews and health checks to improve health were undertaken. The practice had developed a template which allowed GPs to quickly screen patients with suspected dementia.

The practice provided in-house counselling and psychological therapies in collaboration with other organisations, including adolescents. Staff used social media to share information to signpost patients to relevant courses or local supportive events. There was health promotion for local voluntary services for patients, for example Artists in Mind. Patients were provided with information on support services available and referred to various schemes where appropriate, such as the Patient Advice and Liaison Service (PALS).

Summary of findings

What people who use the service say

We spoke with five patients and a member of the patient participation group (PPG) on the day of our visit. The PPG member told us the group's contribution was valued by the practice and they had a genuine interest in their contributions to patient improvement. The patients we spoke with were positive about the care and treatment they received at the practice. Common themes from patients were they felt they were treated with dignity and respect, were listened to and involved in their treatment.

As part of our inspection process, we asked patients to complete CQC comment cards prior to our inspection. We received 22 completed CQC comment cards. All the comments on the cards were very positive and complimentary; many citing the service they received as being 'excellent and fantastic'. These findings aligned with the national GP survey results.

The National GP Patient Survey results published July 2015 showed the practice was performing in line and predominantly above the local and national averages. There was a response rate of 47% to the survey.

- 85% of patients would recommend this surgery to someone new to the area compared to the CCG average of 82% and the national average of 78%
- 98% of patients had confidence and trust in the last GP they saw or spoke to compared to the CCG average of 96% and the national average of 95%
- 94% said the last GP they saw or spoke to was good at listening to them compared to the CCG average of 90% and the national average of 89%
- 91% said the last GP they saw or spoke to was good at giving them enough time compared to the CCG average of 89% and the national average of 87%
- 79% of patients described their experience of making an appointment as good compared to the CCG average of 74% and the national average of 74%
- 93% of patients found it easy to get through to this surgery by phone compared to the CCG average of 74% and the national average of 74%
- 67% of patients said they got an appointment with a preferred GP or usually get to see or speak to that GP compared to the CCG average of 65% and the national average of 61%
- 86% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 86% and the national average of 85%
- 63% of patients said they don't normally have to wait too long to be seen compared to the CCG average of 57% and the national average of 58%

Areas for improvement

Action the service SHOULD take to improve

- Ensure a health and safety risk assessment for the premises is completed and an action plan implemented in accordance with the findings.
- Ensure where the decision has been made not to carry out a DBS check for non-clinical staff who act as chaperones, there is a written risk assessment in place.
- Ensure all staff are aware of the practices business continuity plans.

Elmwood Family Doctors

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 inspector, a GP specialist advisor, a nurse specialist advisor and a practice manager specialist advisor.

Background to Elmwood Family Doctors

Elmwood Family Doctors is located in one of the lesser socially deprived areas of Huddersfield. At the time of our inspection there were 12893 patients on the practice list.

The practice provides Personal Medical Services (PMS) and also offers enhanced services for various immunisation checks, has extended hour's access, remote care monitoring, minor surgery, learning disability, alcohol and people living with dementia health check schemes.

The practice has five male GPs, three female GPs, three female practice nurses, two female healthcare assistants, a practice manager, an assistant practice manager and an extensive administrative team. The practice opening times are Monday to Friday 8am till 6.30pm. Surgery opening times are Thursday and Friday 8.00 to 6.00pm. Extended hours are Monday, Tuesday and Wednesday 8am till 8pm (pre-booked appointments only). When the practice is closed, out of hours cover for emergencies is provided by Local Care Direct.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting the practice we reviewed information we hold about the practice and asked other organisations, such as NHS England Local Area Team and Greater Huddersfield Clinical Commissioning Group (CCG) to share what they knew.

We carried out an announced inspection at Elmwood Family Doctors on the 12 August 2015. During our visit we spoke with a range of staff including three GPs, a practice nurse, a health care assistant, four reception staff, the practice manager and assistant practice manager. We also spoke with five patients who used the service and a representative from the Patient Participation Group (PPG). We observed positive communication and interactions between staff and patients; both face to face and on the telephone within the reception area. We reviewed 22

Detailed findings

completed CQC comment cards where patients had shared their views and experiences of the practice. We also reviewed documents relating to the management of the practice.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents. However, they were unaware of the recording form available on the practice's computer system. The practice manager had identified this as an issue and told us the incident reporting process would be discussed at the next practice protected time (PPT) event. All complaints received by the practice were entered onto the system and automatically treated as a significant event. A designated GP partner carried out an analysis of the significant events and clinical incidents were discussed at weekly clinical meetings and non clinical incidents were discussed at PPT events. We saw evidence of this in the minutes.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events which had occurred during the last 12 months and saw the system was followed appropriately. Staff verbally reported incidents which were assigned to the nominated GP to investigate. We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice

National patient safety alerts were monitored by the assistant practice manager who sent them to a nominated GP who told us would undertake a risks assessment and identifies any actions required.

Reliable safety systems and processes including safeguarding

There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GP attended monthly safeguarding meetings with the health visitor and school nurse. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.

A notice was displayed in the waiting room, advising patients chaperones were available if required. Practice Nurses and two non clinical staff acted as chaperones. The practice nurses had received a disclosure and barring check (DBS). These 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 whose circumstances may make them vulnerable. The non clinical staff who acted as chaperones did not have a DBS check. The assistant practice manager told us non clinical chaperones were never left alone with patients. They said the risks had been considered and appropriate arrangements were in place for staff acting as chaperones. A decision had been made not to carry out a DBS check for non-clinical staff who acted as chaperones. However there was no written risk assessment in place.

Medicines management

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The practice was participating in the Polypharmacy (this is the use of four or more medications by a patient, generally adults aged over 65 years) review initiative by Huddersfield Clinical Commissioning Group (CCG) to ensure safe and effective prescribing to older patients. Patients had regular medication reviews and targeted health checks.

Cleanliness and infection prevention and control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

Appropriate standards of cleanliness and hygiene were followed. The lead nurse was the clinical lead and responsible for undertaking the infection prevention and control (IPC) audit and any actions implemented. There was an IPC protocol in place and staff had received up to date training. The practice had carried out Legionella risk assessments and regular monitoring.

Equipment

Requires improvement

Are services safe?

The majority of electrical equipment was checked to ensure the equipment was safe to use. We noted one item of the portable electrical equipment had not been routinely tested. We saw evidence of calibration of equipment where required, for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy setting out standards it followed when recruiting clinical and non-clinical staff. However, we found the practice was not adhering to their policy and obtaining DBS checks for all staff prior to employment. We looked at three staff files and found pre-employment checks had been undertaken, such as references and professional registration. The majority of the staff had worked at the practice for many years and had not had a recent DBS check.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included dealing with emergencies, for example fire risk assessments. Each risk was assessed, rated and mitigating actions recorded to reduce and manage risk. However, no health and safety risk assessment had been undertaken for the premises.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available. The practice had a defibrillator available on the premises and oxygen with adult and children's masks.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Staff were knowledgeable of actions to take in the event of a major incident, such as power failure or building damage. However they were unaware of the practices business continuity plans. The practice manager told us the plan was being reviewed in line with the CCG procedures. The GP partners told us they had access to an electronic system at home which alerted them to any emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Systems were in place to ensure clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We were told clinicians held weekly meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs and nursing staff they completed thorough assessments of patients' needs in line with NICE guidance and these were reviewed when appropriate. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG).

The GP partners had developed streamlined care pathway templates, for example palliative care templates to ensure patients receiving palliative care followed the same pathway. This enabled GPs to quickly access information and spend more time with patients during their appointments. The practice had developed a standardised template for patient care. We looked at the formulary for anticipatory care drugs on the template for palliative care drugs. This reflected best practice, for example patients were prescribed the appropriate medication.

The practice had close links with a local residential care home for adults who had severe learning disabilities and had significant care needs. All the patients who resided at the home were registered with the practice and they had a named GP. The practice used proactive methods to improve patient outcomes and it linked with other local providers. For example, the practice had initiated fortnightly 'mini ward rounds' in a local disabled young adult residential home to provide additional health care and support.

The practice was participating in the Polypharmacy (this is the use of four or more medications by a patient, generally adults aged over 65 years) review initiative by Greater Huddersfield CCG to ensure safe and effective prescribing to older patients. It had a palliative care lead GP who held regular Gold Standard Framework meetings to ensure good communication between team members looking after palliative care patients, as well as a forum for multi-disciplinary learning.

The practice provided responsiveness care for people experiencing poor mental health, including people living with dementia. Although the practice was not contracted to provide an enhanced service for facilitating timely diagnosis and support for people with dementia. We saw evidence that an enhanced level of service provision was provided above what is required under core General Medical Service (GMS) contracts. Patients had a named GP to ensure continuity.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs demonstrated the culture in the practice was patients were cared for and treated based on need and account of patients' age, gender, race and culture was taken into consideration only when appropriate.

Management, monitoring and improving outcomes for people

The GP partners had lead roles in how they monitored and improved outcomes for patients. These included staffing, information governance, clinical governance, complaints, significant events, safeguarding and business management. Other staff had key roles in data input, scheduled clinical reviews, how they managed child protection alerts and medicines

management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service.

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 99% of the total number of points available. This was higher than the national average of 94%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from August 2015 showed:

- Performance for diabetes related indicators were similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average

Good

Are services effective?

(for example, treatment is effective)

- Performance for mental health related and hypertension indicators were similar to the national average.
- The dementia diagnosis rate was comparable to the national average.

The practice was at or above the national average for many of the QOF domains, particularly in asthma, atrial fibrillation, cancer, chronic kidney disease, dementia, chronic obstructive pulmonary disease, depression, diabetes, heart failure, hypothyroidism, learning disabilities, mental health, palliative care and peripheral arterial disease. The practice proactively used QOF to improve performance. For example it implemented a robust recall system for ensuring flu vaccinations uptake. The practice sent text reminders to patients and ensured people at risk were on the register. In addition, the practice discussed QOF in meetings and we saw evidence in minutes to support this. Flu vaccination rates for the over 65s were 78%, and at risk groups was 54% which were similar to the national averages. The practice nurse provided us with an example that demonstrated how the nursing team responded to the low uptake of flu vaccinations in pregnant women. Appointments were made available during ante-natal clinics to offer opportunistic vaccinations to the women who attended. This increased the vaccination uptake for this group.

Childhood immunisation rates for the vaccinations given were comparable to CCG/National averages. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 86% to 97% and five year olds from 95% to 99%.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had an effective system in place for how they completed clinical audit cycles. We were shown two audits (one clinical and one administrative) which had been completed within the past 12 months. These related to gestational diabetes and the length of time patients waited to see a GP. Following each clinical audit changes to treatment or care had been made where needed and the audit repeated to ensure outcomes for patients had improved.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Evidence reviewed showed that:

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, infection prevention and control, safeguarding, health and safety and information governance.
- Staff received appropriate training to their role. Staff had access to and made use of e-learning training modules.
- All GPs were up to date with their yearly appraisals. There were annual appraisal systems in place for all other members of staff.
- Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties.

Working with colleagues and other services

The practice worked with other service providers to monitor and review patients' needs. We saw minutes identified other health professionals who attended these meetings, for example midwifes, community matron, practice nurse and school nurses. The practice told us about the good working relationship they had with the local home for patients with severe learning disabilities. By having all the residents registered as patients it enabled the staff there to develop a shared understanding and improve patient care. The GPs told us this provided continuity of care for all those residents.

The practice commissioned physiotherapy and podiatry services for its patients. Access to these services was by referral from a GP. The Health Centre also acted as a base for other allied professions not directly linked with the practice, but providing NHS services to patients such as counselling services, diabetic retinopathy clinic (diabetic patients are contacted to attend this) and a pain management clinic. Consultant led clinics were held on the premises providing specialist care for patients closer to their home, for example an eye clinic, orthopaedic clinic and a vasectomy service.

Good

Are services effective?

(for example, treatment is effective)

The practice identified patients who needed ongoing support with their health. It kept up to date registers for patients who had a long term condition, such as diabetes or asthma, which were used to arrange annual health reviews. Registers and annual health checks were also available for those whose circumstances may make them vulnerable, such as those with a learning disability and the over 75s.

The practice had systems in place to manage information from other services, such as hospitals and out of hours services (OOHs). Staff were aware of their responsibilities when processing discharge letters and test results.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP OOHs provider to enable patient data to be shared in a secure and timely manner.

Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from the hospital, to be saved in the system for future reference.

Electronic systems were in place for making referrals which, in consultation with the patients, could be done through the Choose and Book system. The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

We saw that when appropriate information was shared with other services and professionals to meet patients' needs. Shared access of specific information was available to the palliative care team

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Consent forms for surgical procedures were used and scanned in to the medical records.

Health promotion and prevention

The practice offered NHS Health Checks and annual reviews to all its patients aged 40 to 75 years, patients with a learning disability, chronic disease or mental health problem. They offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance. Patients who had a long term condition were invited for a health and medication review. Systems were in place to refer or signpost patients to other sources of support, for example carers direct. The practice worked very closely with other health professionals and community and voluntary services and they were focused on using every opportunity for health promotion. For example Friend to Friend (is a registered charity in, West Yorkshire. They work with older people to enable them to improve their quality of life, combat loneliness and reduce isolation, by providing activities such as Armchair Exercise and Lunches) and Sharing Memories (is a registered local charity in Holme Valley. They work with older people to share their memories of the past with each other and to use these shared memories for creating art works. With the support of two artists)

The practice provided an in-house alcohol prevention service to patients. Two GPs had received training in the Royal College of General Practitioners (RCGP) in the management of alcohol problems in primary care. The GPs supported the specialist (alcohol prevention) nurses to provide weekly appointments to patients.

The practice website provided health promotion and prevention advice, such as long term conditions and had links to various other health websites, for example NHS Choices and Carers Direct.

All practice nurses were trained to advise about leading a healthy lifestyle, certain health problems, foreign travel, and also to perform cervical smears and other medical procedures. Health checks were routinely offered by practice nurses to any patients joining the practice.

The practice had been involved in CCG pilots, such as pathfinder, winter access and breaking the cycle.

Healthy lifestyle information was available to patients via leaflets, posters and a television in the waiting room and also accessible through the practice website. This included management of long term conditions and carers direct. Patients were signposted to other services as the need arose. Staff used social media to share information to signpost patients to relevant courses or local supportive

Good

Are services effective?

(for example, treatment is effective)

events. Patients who may be in need of extra support were identified by the practice. Patients were provided with information on support services available and referred to various schemes where appropriate, such as the Patient Advice and Liaison Service (PALS). They offered a range services, for example anticoagulation, smoking cessation and alcohol reduction clinics to offer care closer to patients' homes, within a rural community which benefited older patients and those with reduced mobility. A weekly mother and baby clinic was held at the practice and those attending had access to a midwife and GP for advice and support.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on.

We reviewed the most recent data available for the practice on patient satisfaction. This included information form the National Patient Survey where from a survey of 257 questionnaires, 122 (47%) responses were received. Results from survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. For example:

- 94% said the last GP they saw or spoke to was good at listening to them compared to the CCG average of 90% and national average of 89%
- 98% said they had confidence and trust in the last GP they saw or spoke to compared to the CCG average of 96% and national average of 95%
- 94% said the last GP they saw or spoke to was good at listening to them compared to the CCG average of 90% and the national average of 89%
- 86% said the last GP they saw or spoke to was good at treating them with care and
- concern compared to the CCG average of 88% and the national average of 85%
- 94% said the last nurse they saw or spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%

Patients we spoke with and the CQC comment cards confirmed this. Patients spoke highly of the staff at the practice. They told us they were treated with kindness, compassion, dignity and respect whilst they received care and treatment. We reviewed 22 completed CQC comment cards patients had completed prior to the inspection and spoke with five patients and a member of the PPG on the day of inspection.

Systems were in place to maintain patients' confidentiality. These included taking patients to a private room to continue a private conversation and transferring confidential telephone calls to a private room if a person rang the practice for investigation results. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception desk was separate from the two patient waiting rooms to maintain patient confidentiality.

We observed positive interactions in the reception area and saw staff treated patients with kindness and warmth. We heard shared laughter between patients and staff which demonstrated staff had a good rapport with patients and knew them well. Staff could also provide examples of how they supported patients to cope emotionally with their care and treatment in a timely and appropriate manner.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. There was a separate room in the treatment rooms with privacy curtains to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted consultation/treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

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

- 89% said the last GP they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%
- 91% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%

The practice scored below the CCG and national average for GPs involving them in decisions about their care, for example:

- 78% said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%

However, patients we spoke with and the CQC comment cards we viewed confirmed that health issues were discussed with them and they felt involved in decision

Good

Are services caring?

making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 90.6% said the last GP they saw or spoke to was good at giving them enough time compared to the CCG average of 89% and national average of 86.8%

Patients we spoke with on the day of our inspection and the CQC comment cards we received highlighted staff were caring, compassionate and provided support when needed. They told us they had a named GP, who was kind, sympathetic and met their emotional needs.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. GPs told us that they were able to signpost carers to local support services and a member of staff was training to become a carer's champion. In addition, the practice provided patients with an in-house bereavement service. The GP partners told us if families had experienced bereavement they always undertook a home visit to support the bereaved person. Patients had support from a health trainer who worked in collaboration with Kirklees Council. In addition there was a carers champion (a person who supports carers to access support and information more easily). The practice provided in-house counselling and psychological therapies in collaboration with other organisations, including adolescents.

Regular palliative care meetings were held to support patients' needs and they had an assigned GP. The practice used the facilities at Holme Valley Memorial Hospital run by Mencap. Patients could be admitted for treatments such as physiotherapy or rehabilitation. In addition, patients had access to a cafe at the hospital if patients were waiting for appointments or transport home.

Patients we spoke with commented on how they felt cared for and supported by staff. The GP partners spoke passionately and enthusiastically about providing good patient care and how they always supported and accommodated patients where possible. They told us they knew the patients well and had built up a good relationship with them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they engaged regularly with Greater Huddersfield CCG and other agencies to discuss the needs of patients and service improvements. One of the GPs was a board member of the CCG which enabled them to have a good working knowledge of the local area. The practice had been involved in CCG pilots, such as winter access (additional GP access or services over the winter using funding allocated to the NHS for winter pressures) and breaking the cycle (to improve patient flow by producing a step-change in performance, safety and patient experience). We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had initiated positive service improvements for its patients that were over and above its contractual obligations.The practice had undertaken an audit of appointments and home visits to identify pressure points, GP capacity and patient demand. This also included feedback from the friends and family test. This initiative enabled them to allocate appointments based on patient need and identify in advance when locums were required.

The practice demonstrated good and improved access to sexual health services to young people. They had strong links with local schools and worked collaboratively with the school nurses to support and advise young people. Young people at schools had direct access to same day appointments for emergency contraception, when the school nurse may accompany the patient. In addition, the practice worked collaboratively with the local pharmacy to dispense the emergency pill from the practice to preclude the need for patients to visit the chemist. This had encouraged teenagers to seek health advice and the practice had been able to support and safeguard children through this service.

Older people with mobility difficulties were supported by the local Holme Valley Transport Scheme. The three care/nursing homes the practice visited offered a compassionate and responsive service. The practice worked closely with the homes and offered weekly visits, telephone guidance and advice to support the residents. All patient and residents at the homes had a named GP to undertake regular reviews and to ensure continuity of care. This enabled the named GPs to develop working relationships with family members/carers as well as to identify any safeguarding concerns.

Residents in a local disabled young adult residential home had a named GP to ensure continuity of care. A named GP visited the home on fortnightly and on a needs basis to undertake 'mini ward rounds'. In addition the GP had annual meetings with the families of the residents. The GP partners told us they were always available for advice and support by telephone. It carried out annual health checks and offered longer appointments for people with a learning disability. Patient status alerts were used within the clinical system to make staff aware when they were dealing with a patient whose circumstances may make them vulnerable. The practice used clinical meetings and daily doctors meetings in the case management of these people.

The practice had a daily designated duty doctor to ensure patients could quickly access urgent appointments. The nominated duty GP had allocated urgent patient appointments during their day and took time with patients to deliver health promotion and advice. The GPs and nurses supported each other as necessary to ensure the best possible service was given to patients. It was evident from our interviews that the clinical team was passionate about their work and where they worked.

The practice held daily coffee meetings with clinical staff including the midwife and community matron to discuss any issues and to also provide team support. They acted on suggestions for improvements and changed the way they delivered services in response to feedback from the friends and family test and also the patient participation group (PPG).

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. The practice had systems in place which alerted staff to patients with specific needs or who may be at risk. For example, patients who may be living in vulnerable circumstances.

The majority of the practice population were English speaking but access to interpreting services was available if required. The practice had a website function which

Good

Are services responsive to people's needs?

(for example, to feedback?)

enabled information to be translated into a variety of languages. Additional services within the practice were available for patients who may have a hearing or visual impairment, for example a screen calling system. The electronic system identifies patients that need collecting from reception.

The practice was in a large purpose built building, it was accessible to patients with mobility needs. The consulting rooms were also accessible for all patients and there were access enabled toilets and baby changing facilities. We observed the two waiting rooms had enough space for wheelchairs and prams. There were also designated car parking facilities for disabled patients.

Access to the service

The practice opening times are Monday to Friday 8am till 6.30pm. Surgery opening times are Thursday and Friday 8.00 to 6.00pm. Extended hours are Monday, Tuesday and Wednesday 8am till 8pm (pre-booked appointments only). Information regarding the practice opening times and how to make appointments was available in the practice leaflet and on the practice and NHS Choices website. Patients could book appointments by telephone, online or in person at reception. Some appointments were pre-bookable and some were allocated to be booked on the same day. The practice also offered a triage system whereby they could speak with a GP for advice. Home visits were offered for patients who found it difficult to access the surgery. Urgent appointments were available on the same day. In addition there was a text system in place. This was used to inform patients of test results, a reminder of annual reviews and GP appointment reminders. The practice had a daily designated duty GP to ensure patients could quickly access urgent appointments.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey. This indicated patients were happy with the appointments system at the practice. For example:

- 79% described their experience of making an appointment as good compared to the CCG average of 74% and the national average of 74%
- 93% found it easy to get through to the practice by telephone compared to the CCG average 74% and the national average of 74%
- 67% said they usually get to see or speak with their preferred GP compared to the CCG average of 65% and the national average of 60%
- 92% say the last appointment they got was convenient compared to the CCG average of 91.9% and the national average of 92%
- 76% patients said they usually wait 15 minutes or less after their appointment to be seen compared to the CCG average of 66% and the national average of 65%
- 63% patients felt they don't normally have to wait too long to be seen compared to the CCG average of 57% and the national average of 58%

Patients we spoke with were extremely satisfied with the appointments system and said it was easy to use. The patient comments on the 22 completed CQC comment cards were aligned with these views. They confirmed that they could see a GP on the same day if they felt their need was urgent though this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Appointments were available outside of school hours for children and young people.

The practice was innovative and proactive with respect to providing online access and identifying patient demand for appointments. One of the GP partners had undertaken a 12 month audit of appointment analysis of both capacity and patient demand. The findings of the audit highlighted the practice's busy days (to keep more "same-day" access on those days as standard). It also showed a cut off of a minimal number of appointments per week that they needed to offer. This reduced the volume and unpredictability of unscheduled work and created extra appointments for patients. The figure identified following the audit acted as a trigger for the administrative team to manage an interactive rota spreadsheet and enabled them to act autonomously in planning staff annual leave. The

Good

Are services responsive to people's needs?

(for example, to feedback?)

rota spreadsheet highlighted if the number of annual leave requests dropped below the critical figure. This allowed the GP partners to rearrange working patterns or employ locums in advance.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. Information about how to make a complaint was available on the practice website and in a practice leaflet. The practice manager told us that the complaints process would be displayed clearly for patients in the waiting area. The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

Patients we spoke with told us they did not have any complaints but knew how to make a complaint should they need to. They told us they were extremely happy with the care they received and it was an excellent service.

We looked at how complaints received by the practice in the last 12 months had been managed. Clinical complaints were dealt with by a GP partner and the practice manager dealt with all non-clinical issues. The records showed all complaints had been dealt with in line with the practice policy and in a timely way. Patients had received a response which detailed the outcomes of the investigations. We saw evidence actions and learning from complaints was discussed at practice meetings and shared with staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients through innovation and excellence. Our discussions with staff indicated the vision and values were embedded within the culture of the practice and patient care was a priority. The GP partners were passionate and enthusiastic about the services they provided. They told us they always tried to do their best for patients to deliver a good service and they recognised the importance of the different needs of the population groups in delivering services. The practice was proactive and planned ahead to the future of the NHS and recognised the challenges this might bring. For example ensuring capacity in their current ways of working allow for adaptations for future demands.

Governance arrangements

The practice had good governance arrangements in place to ensure risks were identified, understood and managed appropriately. We saw risk assessments and the control measures in place to manage those risks for example fire and infection control. However there was no health and safety risk assessment.

The GP partners were knowledgeable of staffs' strengths and skills. There was a clearly defined staffing structure and staff awareness of their own roles, responsibilities and expectations. The practice carried out proactive succession planning. They told us they preferred to be over doctored to have a higher GP to patient ratio. Practice specific policies were implemented and all staff had access to them. There was a system of continuous audit cycles which demonstrated an improvement on patients' welfare.

The practice had clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information. There were daily coffee meetings, weekly GP meetings and two monthly PPT meetings will all staff.

The GPs were all supported to address their professional development needs for revalidation and all staff in appraisal schemes and continuing professional development.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. This was evident from discussions with staff and from records we reviewed. GP partners provided strong leadership by championing the care of people with learning disabilities, older people and people experiencing poor mental health by visiting patients in residential homes and signposting to relevant services such as Artists in Mind (This is a charity that supports adults experiencing poor mental health). Staff told us the GPs and practice manager were approachable, and supportive.

Staff spoke positively about the practices visions and values. Many citing that they aspired to provide good care. They told us there was an open culture within the practice and they felt engaged and the practice management team listened and acted on their ideas and suggestions.

The GP partners spoke positively about the practice and how they worked collaboratively as a team and with other health professionals in meetings the needs of patients. They attended numerous meetings which included daily coffee meetings, medicines management, safeguarding, case conferences, staff meetings, multi-disciplinary meetings, GP partner meetings and PPT events. One GP partner told us that communication was important within the practice to enable staff to understand patient safety priorities.

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

The practice had actively gathered feedback from patients through patient surveys, friends and family test and complaints received. The practice sought the views of patients through the Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG was a small group of enthusiastic volunteers who helped the practice devise a patient survey for the last two years, to seek the views of patients. It was clear from discussions with the PPG member and from the minutes we reviewed that the practice was actively engaged with the PPG.

The PPG survey had identified areas for improvement at the practice, for example improvements to the internal physical appearance to the health centre. The practice discussed with the PPG the interim measures they could implement and actions were agreed, such as the

Are services well-led?

Good

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

redecoration of the waiting room. As a result of the survey, the practice had undertaken an appointment analysis which had resulted in setting up an appointment text reminder system. We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged and listened to by the practice.

The practice worked with patients and the local community in a collaborative way to improve services and they were continually looking to improve and promote services using social media such as Facebook.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. They told us annual appraisals took place, which included a personal development plan. This was evidenced in the staff files we looked at.

The practice used complaints, audits and significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients. The practice had completed reviews of significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients. We saw evidence of this in minutes of meetings and logs of events.

Staff received an induction, regular performance reviews and they felt supported by the practice.