

Ash Grove Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Good



Are services effective?

Good



Are services caring?

Requires improvement



Are services responsive to people's needs?

Requires improvement



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 Requires improvement overall.

The practice had been rated as Good overall at the previous inspection carried out on 19 January 2016.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Requires improvement

Are services responsive? – Requires improvement

Are services well-led? – Good

As part of our inspection process we also look at the quality of care for specific population groups. The issues identified as requiring improvement overall affected all patients. In addition the provision of effective services for people with long-term conditions was also rated as requiring improvement. The population groups are rated as:

Older People – Requires improvement

People with long-term conditions – Requires improvement

Families, children and young people – Requires improvement

Working age people (including those retired and students) – Requires improvement

People whose circumstances may make them vulnerable – Requires improvement

People experiencing poor mental health (including people with dementia) – Requires improvement

We carried out an announced comprehensive inspection at Ash Grove Medical Centre and Whitleybridge branch surgery on 6 December 2017. The inspection was carried out as part of our inspection programme and was also used to follow up areas where the provider had been informed previously that they should make improvement.

At this inspection we found:

- The practice had clear systems and processes in place to manage risk so that safety incidents were less likely to happen. When incidents did happen we saw that these were investigated by the practice and that processes were revised and improved to prevent a recurrence.
- The practice had experienced a high turnover of staff over a period of time and this had reduced their capacity to deliver services. The practice had actively sought to recruit additional staff and had implemented new processes to redress this.

Summary of findings

- Patients reported difficulty in contacting the practice and accessing services. In addition patient satisfaction in relation to their involvement in decisions about their care and treatment were significantly below local and national averages.
- 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.
- The practice was actively involved in health improvement activity, and took part in a number of local and national improvement initiatives. For example the practice worked with a local NHS Trust who provided a telemedicine service to two local nursing homes.
- The practice provided additional services for those with mental health needs and dementia. For example the practice had received accreditation for both its work to support dementia patients and for learning disability patients.
- Improve the identification of carers to enable this group of patients to access the care and support they require.
- Review and improve the systems in place so that reviews of patients are completed in accordance with their care and treatment requirements.
- Review areas of poor patient satisfaction with the services provided and take steps to improve satisfaction in these areas. This should include telephone and appointment access and patient's feeling involved in planning and making decisions about their care.
- Review and risk assess the decisions made with regards to choosing not to stock certain emergency medicines in line with recognised guidance.
- Review and improve quality improvement activity within the practice, including the effective use of clinical audit.

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

The areas where the provider **should** make improvements are:

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

Ash Grove Medical 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 Ash Grove Medical Centre

Ash Grove Medical Centre is located on England Lane, Knottingley, Wakefield, WF11 0JA; it also operates the Whitleybridge branch surgery which is located at 87 Selby Road, Eggborough DN14 0LJ. Both main and branch surgeries currently provide services for around 13,000 patients. The main surgery at Knottingley is a purpose built unit and was opened in 2009; it is of modern design with parking available on site and is accessible to those with a disability. The branch surgery is located in a converted commercial business with parking available and is also accessible to those with a disability. Both the main surgery and the branch surgery have pharmacies either within the same building or adjacent to them. The practice is a member of the NHS Wakefield Clinical Commissioning Group (CCG.)

The practice population age profile shows that it is slightly above the England average for those over 65 years old (19% of the practice population is aged over 65 as compared to the England average of 17%), additionally 61% of the practice population reported a long standing health condition compared to an England average of 53%. Average life expectancy for the practice population is 77 years for males and 82 years for females (England average is 79 years and 83 years respectively). The practice is

located in an area of relative deprivation being rated 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 and is registered with the Care Quality Commission (CQC). The practice offers a range of services which includes:

- Childhood vaccination and immunisation
- Influenza and Pneumococcal immunisation
- Minor surgery
- Learning disability support
- Extended hours
- Services supporting chronic disease management including asthma, chronic obstructive pulmonary disease, heart disease and hypertension

The Whitleybridge branch surgery offers a more limited range of services which necessitates patients traveling to the main practice to receive some treatments and services such as minor surgery.

Within the main practice premises external providers deliver services including physiotherapy, podiatry, and substance misuse support.

The practice has five GP partners (four male, one female). In addition there are two advanced nurse practitioners (female), three practice nurses (female) two triage nurses (female), five health care assistants (female), one apprentice health care assistant (female) and two phlebotomists (female). Clinical staff are supported by two practice managers, a large secretarial/reception team and a building maintenance and cleaning team.

The practice offers a range of appointments, these include:

Detailed findings

- Routine pre-bookable appointments up to four weeks in advance
- Urgent appointments/on the day appointments – if a patient calls with an urgent medical condition and requires an appointment on the same day they are added to a triage list and a GP or nurse would call back to offer treatment advice over the phone or book an appointment on the day should this be required.
- Telephone appointments/consultations are available for accessing test results, fitness to work notes and general health advice.

Appointments can be made in person, via the telephone or on-line.

The practice operates a triage system for incoming telephone calls whereby incoming callers are added to a same day call back list and are then contacted by a duty GP assisted by advanced nurse practitioners. The patient is then assessed and offered a range of options including appointments for that day or another day, home visits or are signposted or directly referred to a more appropriate service, such as a pharmacy.

The main Ash Grove Medical Centre is open Monday to Friday 8am to 6.30pm. Early surgeries are available 7am to 8am Monday and Tuesday and late surgeries operate 6.30pm to 8pm Monday, Wednesday and Thursday.

The Whitleybridge branch surgery is open 8.30am to 12.45pm Monday to Friday.

The practice had an online presence www.ashgrovesurgery.co.uk, and offered services including online appointment booking, ordering repeat prescriptions and limited information from medical records.

Out of hours care is provided by GP Care Wakefield and can be accessed via the practice telephone number. It operates from 6.30pm to 10pm Monday to Friday and 9am to 3pm at weekends. In addition patients can also contact NHS 111.

The previous inspection rating of Good is clearly displayed on the practice website and within both the main surgery and branch surgery.

Are services safe?

Our findings

We rated the practice as good for providing safe services overall and across all population groups.

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff either on the practice computer system or in hard copy. They outlined clearly who to go to for further guidance.
- 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, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken for all staff. (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. GPs were trained in safeguarding to level three, members of the nursing team to level two and all other reception and administration staff to level one. They knew how to identify and report concerns.
- We were told by staff who acted as chaperones that they had been trained for the role and saw evidence that they 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 last IPC audit showed high levels of compliance, the main surgery received an overall score of 99% and the branch surgery a score of 92%, the practice was able to show progress against issues that had been identified as part of these audits. We saw from staff records that necessary immunity status checks had been made on staff.
- The practice had procedures in place which ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. However it was noted that a blood pressure monitor within a doctor's bag had last been calibrated in 2014.
- There were systems for safely managing healthcare waste and that waste was being properly stored in an appropriate manner in both surgeries.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. However it was noted that reception staff needed additional awareness training regarding the identification of patients with specific symptoms of sepsis so they could be fast tracked urgently through the appointment and triage system. Since we raised this issue with the practice we have been informed that they have distributed information to all staff in relation to sepsis and have planned to deliver a staff update on sepsis at the next team meeting.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

Are services safe?

- 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.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had 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 only carried a small range of emergency medicines. There had been no formal risk assessment carried out to support decisions made not to carry specific medicines for emergency use. The practice kept prescription stationery secure within the two surgeries.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice showed comparable performance to other providers for the prescribing of antibiotics.
- Patients' health was monitored to ensure medicines were being used safely and followed up appropriately. The practice reviewed and monitored patients on high risk medicines at necessary intervals.

Track record on safety

The practice had a satisfactory safety record.

- There were comprehensive risk assessments in relation to safety issues and at the time of inspection the practice was in the process of reviewing their health and safety risk assessments.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. In 2017 the practice had recorded 12 significant events and incidents.
- 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 experienced an issue when blood samples had not been submitted for collection at the appropriate time which required patient blood samples to be retaken and resubmitted. In response to this a new system was introduced for the submission of pathology samples. Patients affected by such incidents were apologised to.
- There was a system for receiving and disseminating safety alerts, and we saw that recent alerts had been actioned appropriately. We were told that the practice learned from external safety events as well as patient and medicine safety alerts, and we were told, and saw evidence to support this, that these were discussed at team meetings.

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 except for people with long-term conditions which we rated as requires improvement.

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 assessed. This included their clinical needs and their mental and physical wellbeing.
- Data from 2016/17 showed that the practice was comparable to others locally and nationally for the prescribing of hypnotic medication (medicines which work in the body to relieve anxiety, aid sleep or have an otherwise calming effect) and antibacterial products.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review which included a review of medication.
- Overall Quality Outcome Framework performance in relation to osteoporosis (a condition that weakens bones and makes them fragile and more likely to break) was 100% and was above the CCG average of 87% and the national average of 90%.
- The practice utilised the services of a pharmacist who carried out reviews of patients on multi-medications to ensure that these were effective and safe and if appropriate to seek to reduce the amount of medication they received.

- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and were supported by an appropriate care plan.

People with long-term conditions:

- Patients with long-term conditions were offered structured annual reviews to check that their health and medicines needs were being met. Reviews were flexible to the needs of the patients and when appropriate were carried out via telephone as well as through face to face consultations.
- Whilst available outcome measures showed that practice performance was generally comparable to other practices, it was below the local and national averages for a number of measures in relation to long-term conditions. For example:
- Overall Quality Outcome Framework performance in relation to diabetes was 65% compared to CCG and national averages of 91%.
- Overall Quality Outcome Framework performance in relation to hypertension was 74% compared to CCG average of 99% and a national average of 97%.
- Overall Quality Outcome Framework performance in relation to Chronic Obstructive Pulmonary Disease (a collection of lung diseases including chronic bronchitis and emphysema) was 69% compared to CCG and national averages of 96%.

We discussed this with the practice who told us that this was due to the impact over the past 18 months of the loss of a number of key members of clinical staff. In response to this the practice was in the process of recruiting and appointing further clinical staff and had also revised working practices and procedures. Actions have included:

- Utilisation of GPs, in addition to members of the nursing team, to perform annual diabetic reviews due to the high numbers of patients on the diabetic register (812). This process change had shown a positive impact and at the time of inspection the practice had carried out 68% of their total diabetic reviews.
- The practice had trained one of their health care assistants to support the hypertension review process working alongside GPs. At the time of inspection 66% of their hypertension reviews had been carried out.

Are services effective?

(for example, treatment is effective)

The practice sought to deliver against a specific CCG contract regarding local care planning for six conditions which included asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, chronic kidney disease, heart failure and end of life care. This required the practice to provide annual face-to-face care planning consultations with patients of at least 20 minutes duration (longer for those with more than one condition). The target was to complete 100% for these reviews. The latest figures for October 2017 showed performance of around 55% against a target of 58%.

- For patients with the most complex needs, the practice planned and delivered services with other health and care professionals. This delivered a coordinated package of care to meet the specific needs of the patient.
- The practice delivered multi-condition review clinics for patients with a number of long term conditions. These were run by GPs and members of the nursing team which resulted in patients having to visit the medical centre only once to have all their reviews carried out. In addition nursing home patients were provided with an individual patient pack which contained templates for all their long-term conditions, details of samples taken and test results and consent forms. This also supported the delivery of multi-condition reviews which saved repeated visits to the patient.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example a practice nurse had received additional diabetic training to further support these patients, which also allowed them to initiate insulin.

Families, children and young people:

- Childhood immunisations were carried out and were above the national childhood vaccination programme target of 90%.
- The practice operated well-man and well-woman clinics and used these to carry out health checks and to deliver key health messages.

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

- The practice's uptake for cervical screening was 78%, and which was slightly below the 80% coverage target

for the national screening programme. The practice informed patients when cervical screening dates were due and further contacted patients when they had not set or attended for a screening appointment.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- During Saturday flu clinics the practice also conducted a health care assistant led wellbeing clinic which offered weight and blood pressure checks and advice on stopping smoking.

People whose circumstances make them vulnerable:

- The practice worked with other health care professionals to support and coordinate care for patients coming towards the end of life. This took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and the frail elderly with complex needs.
- A dedicated health care assistant carried out regular visits to two learning disability homes to support residents with their specific needs. The health care assistant worked closely with the lead GP for mental health. In 2017, 34 learning disability health checks had been carried out, of which 29 had been completed in residential home settings.
- The GP lead for mental health carried out weekly shared care clinics with the local drug and alcohol team which consisted of face to face reviews with the patients and their families. At the time of inspection the practice had completed 25 shared care reviews of patients.

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

- 86% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was above the CCG and national averages of 84%.

Are services effective?

(for example, treatment is effective)

- 90% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the CCG average of 93% and the national average of 91%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 100% compared to a CCG average of 92% and a national average of 91%.
- A partner from the practice had worked with other health professionals locally and had developed the SHARP (Self-help Access in Routine Primary Care) programme. This programme was designed to enable primary care practitioners to support patients with mild to moderate anxiety and/or depression issues to access Cognitive Behavioural Therapy (CBT) based self-help information. Whilst the programme itself was no longer running, the website was still in operation and self-help information leaflets could be downloaded by practitioners to give to patients.

Monitoring care and treatment

The practice had carried out some quality improvement activity and had reviewed the effectiveness and appropriateness of the care provided. For example the practice had examined and analysed effectiveness with regard to the practice triage processes. The practice had also carried out some clinical audits activity, although these audits lacked depth and had not been carried out over two full cycles.

The most recent published Quality Outcome Framework (QOF) results for 2016/17 showed that the practice had achieved 90% of the total number of points available compared with the clinical commissioning group (CCG) and national averages of 96%. The overall exception reporting rate for the practice was 10% which was comparable to the 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.) However certain indicator

measures such as exception reporting in relation to mental health reviews were well above the national average at 63% compared to a CCG average of 11% and a national average of 13%. When we discussed this with the practice they told us that their aim was to review all 137 patients on their mental health register on an annual basis and that these patients were contacted on three separate occasions per year to attend a review appointment. They acknowledged that it had been difficult to engage with this cohort of patients. The practice told us that in light of this data it would examine exception reporting further.

The practice was actively involved in health improvement activity, and took part in a number of local and national improvement initiatives. For example:

- They had participated in the Wakefield Vanguard programme (Vanguard programmes, led by NHS England, sought to support the development of improved health and care models). As part of this work the practice had introduced pharmacists to support patients by carrying out medication reviews and had trained staff to act as care navigators. This training meant that initial contacts with the practice would not necessarily default to a GP appointment. Care navigators sought to understand what the problem related to at the initial point of contact and helped and guided patients to the right profession or service, for example to a pharmacy.
- The practice participated in a trial of a late home visiting service whereby requests for home visits received from 1pm to 5pm were referred on to the community matrons who would then visit the patient and deal with their issues. This meant that if appropriate, patients received visits that day rather than having to wait until the next day.
- The practice worked with a local NHS Trust who provided a telemedicine service to two local nursing homes (Telemedicine is the use of telecommunication and information technology to provide clinical health care and support from another location and at distance).

Effective staffing

The practice informed us that over the previous 18 months they had suffered from reduced clinical and administrative capacity due to the long-term illness, retirement and resignation of a number of staff. This had had a negative

Are services effective?

(for example, treatment is effective)

impact on the level of service and particularly on the availability of appointments. In response to this the practice had introduced new working procedures and sought to develop staff to deliver higher level services. In addition, the practice was involved in recruitment exercises. This had shown some success and an advanced nurse practitioner was due to join the practice in January 2018.

During the inspection, staff demonstrated that they had the skills, knowledge and experience to carry out their roles. For example, staff whose role included supporting diabetic patients 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. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audits of their clinical decision making.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that 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 worked with other health care professionals to support and coordinate care for patients coming towards the end of life. This took into account the needs of those whose circumstances may make them vulnerable. We saw that the practice planned to meet with others on a monthly basis to discuss patients at the end of life, although it was noted that at times these meetings had lapsed or had not been held as frequently.

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 signposted patients to weight management support groups.
- The practice showed effective cancer referral. Data from 2015/16 showed that 55% of new cancer cases used the urgent two week wait referral pathway compared to a CCG average of 49% and a national average of 50%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We rated the practice as requires improvement for providing caring services overall and across all population groups.

The practice was rated as requires improvement for caring because:

- The practice was significantly below both local and national averages for its satisfaction scores on consultations with GPs and nurses.
- The practice had identified only a limited number of patients who were carers.

Kindness, respect and compassion

We saw mixed evidence that staff treated patients with kindness, respect and compassion.

- From conversation with staff we saw that understood patients' personal, cultural, social and religious needs.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. In addition on the day of inspection we saw that the needs of challenging patients were being met.
- We received 26 Care Quality Commission comment cards which contained the views of patients. The majority of these were positive about the care they had received at the practice. However a small number raised issues in relation to staff attitude and the care offered.

Results from the July 2017 annual national GP patient survey showed most patients felt they were treated with compassion, dignity and respect. As part of the survey 250 questionnaires were sent out and 109 were returned for a response rate of 44%. This represented about 1% of the practice population. The practice was below both local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 73% 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%.
- 70% of patients who responded said the GP gave them enough time compared with the CCG average of 85% and the national average of 86%.

- 85% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG and national averages of 95%.
- 68% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 84% and the national average of 86%.
- 84% of patients who responded said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 84% of patients who responded said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 90% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG and national averages of 97%.
- 81% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG) and national averages of 91%.
- 70% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

The practice was aware that the current staffing and capacity issues had had a negative impact on patient satisfaction. In response to these results and others received as part of the national GP survey, the practice had developed an action log. Actions within this included:

- The recruitment of additional reception staff to receive calls to the practice.
- The provision of training for reception staff on subjects such as customer care and care navigation.
- The development and roll-out of one-stop shops. Whereby all long-term condition reviews and medication reviews were carried out at one appointment.
- The continued recruitment of additional clinical staff.
- The development of a new approach to care planning which was launched in May 2017 which aimed to increase the amount and quality of care planning.

Are services caring?

- All patient requests for same day treatment or advice were triaged to ensure patients are seen by the most appropriate clinician.
- Awareness raising amongst patients of access options which included those delivered in extended hours or out of hours.

These actions were either still in the process of being completed or the impact of these changes had not yet been measured and assessed by the provider in terms of improving patient satisfaction.

Involvement in decisions about care and treatment

The practice had some equipment and processes in place which helped patients to become involved in decisions about their care, and they 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):

- Translation and interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, a hearing loop was available and some information materials were in an easy read format.
- Staff were knowledgeable with regard to other local health and care services and supported patients or their carers to identify and access community and advocacy services.

The practice identified patients who were carers. The practice's computer system alerted clinicians if a patient was also a carer. The practice had identified 87 patients as carers (less than 1% of the practice list). Staff referred identified carers to local support organisations and invited carers for annual flu vaccinations. We saw that support service information for carers was displayed in waiting areas.

Staff told us that if families had experienced bereavement that they would signpost them to external support services and groups and that they could access consultations to meet the family's wider health and wellbeing needs.

Results from the national GP patient survey showed patients had responded with satisfaction scores below local and national averages to questions about their involvement in planning and making decisions about their care and treatment:

- 69% 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%.
- 55% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the clinical commissioning group (CCG) average of 80% and the national average of 82%.
- 79% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) and national averages of 90%.
- 70% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the clinical commissioning group (CCG) average of 84% and the national average of 85%.

We discussed these results with the practice and they told us that the measures put in place to improve care planning and recruitment of additional staff should have a positive impact on future results. However some of these actions were either still in the process of being completed or the impact of these changes had not yet been measured and assessed by the provider in terms of improving patient satisfaction.

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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice and all of the population groups as requires improvement for providing responsive services.

The practice was rated as requires improvement for providing responsive services because:

- Patients reported extreme difficulty in being able to contact the practice and being able to access appointments and other services. This was confirmed by the practice who had experienced a reduction in clinical capacity and a consequent reduction in the availability of appointments. This was applicable to all population groups.

Responding to and meeting people's needs

The practice had taken some steps to meet the needs and to take into account patient preferences.

- The practice understood the needs of its population and had tailored services in response to some of those needs. For example the practice offered extended opening hours and online services such as for repeat prescription requests.
- The practice improved or offered enhanced services where possible in response to unmet needs, such as through the provision of specialist diabetic clinics.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example the practice had a hearing loop available for those patients with hearing difficulties and made home visits to patients with specific needs such as the frail elderly and those with a learning disability.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

All of the population groups were rated as requires improvement for receiving responsive services because patients reported extreme difficulty in being able to contact the practice and being able to access

appointments and other services. This was confirmed by the practice who had experienced a reduction in clinical capacity and a reduction in the availability of appointments.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. In addition at the time of inspection the practice participated in a trial of a late home visiting service whereby requests for home visits received from 1pm to 5pm were referred on to the community matrons who would then visit the patient and deal with their issues.
- The practice worked with a local NHS Trust which provided a telemedicine service to two local nursing homes.

People with long-term conditions:

- Some patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with other local health professionals to discuss and manage the needs of patients with complex medical issues.
- The practice worked closely with secondary care partners and delivered a joint diabetes clinic on a quarterly basis for those with more complex needs in conjunction with a specialist diabetes consultant. The clinic had provided services to 98 diabetic patients in 2017. In addition a practice nurse had received further training which allowed them to initiate insulin; at the time of inspection 26 patients had received insulin initiation via this route.
- One of the health care assistants within the practice had completed additional training which allowed them to support GP led reviews of patients with hypertension.

Are services responsive to people's needs?

(for example, to feedback?)

This included pre-review data collection and ensuring all necessary tests have been carried out. In 2017 the health care assistant had supported the completion of 33 hypertension reviews.

Families, children and young people:

- There were systems to identify and follow up children living in disadvantaged circumstances or who were at risk.
- The practice offered additional asthma clinics after school and during school holidays.
- Parents or guardians calling with concerns about a child under the age of 8 were prioritised dependent on the condition.
- The practice offered a catch up service for measles, mumps and rubella, and meningitis vaccines for students aged 17 and above.
- The practice supported a local school that had recently bought a defibrillator. An advanced nurse practitioner liaised with the school and went out and delivered training in its use to staff.

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 flexible and offered continuity of care. For example, it offered extended opening hours and access to out of hours and weekend services.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Patients were able to book appointments and order repeat prescriptions online.
- The practice utilised text messaging for a number of purposes such as reminding patients of appointments or inviting them to flu clinics. In addition patients could cancel appointments via text message.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances this included those with a learning disability and the frail elderly with complex needs.

- The practice was a food voucher distribution site and was able to give these to patients in need.
- 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.

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

- Staff we spoke with had a good understanding of how to support patients with mental health needs and those patients living with dementia. For example, the lead GP for mental health within the practice had worked with other health professionals locally to develop the SHARP mental health self-help programme and supporting resources.
- The practice held GP led dedicated mental health and dementia clinics. In addition the practice had hosted other local mental health service providers who held stress/wellbeing related workshops for patients.
- A dedicated health care assistant supported patients in two local learning disability homes. The health care assistant also made home visits to patients living with dementia to carry out reviews and held specialised in practice clinics for dementia patients.
- The practice was working towards becoming dementia friendly. It had made changes within the medical centre to support patients living with dementia or memory issues. These included, the installation of clearer signage and specific changes to equipment such as fitting colour contrasting toilet seating.

Timely access to the service

Feedback from patients via a number of sources indicated that at times patients were unable to access care and treatment from the practice within an acceptable timescale. They reported issues in relation to contacting the practice and in obtaining an appointment. We discussed this with the practice and they acknowledged that they currently had capacity issues that they were working to resolve. At the time of inspection the next routine appointment available to patients was in three weeks. Whilst the patient list had remained approximately the same as at the time of the last inspection in 2016 we saw evidence from the practice that showed a reduction in

Are services responsive to people's needs?

(for example, to feedback?)

face-to-face consultations carried out from 2909 in June 2016 to 2153 in June 2017. These figures do not take into account telephone consultations or patients who were navigated to a more appropriate service in this period and who therefore did not require a face-to-face consultation.

However despite this performance, we did see that patients with the most urgent needs had their care and treatment prioritised. For example, babies and children under eight years old were prioritised on the triage list dependent on their condition.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and national averages. This was supported by a significant number of comment cards we received from patients. As part of the survey 250 questionnaires were sent out and 109 were returned for a response rate of 44%. This represented approximately 1% of the practice population.

- 51% 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%.
- 42% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 65% and the national average of 71%.
- 70% 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 with the CCG average of 82% and the national average of 84%.
- 63% of patients who responded said their last appointment was convenient compared with the CCG average of 80% and the national average of 81%.
- 36% of patients who responded described their experience of making an appointment as good compared with the CCG average of 68% and the national average of 73%.
- 30% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 60% and the national average of 58%.

We discussed these results with the practice and they told us that measures were being put in place to recruit

additional/new staff and to raise awareness amongst patients of access options. However as many of these actions were still in the process of being completed or had had little time to have an impact the practice could not evidence any actual improvement in patient satisfaction with regard to accessing care and treatment. It was noted though that a newly recruited advanced nurse practitioner was due to start work at the practice in January 2018.

Results from the NHS Friends and Family Test showed that in 2017:

- 69% of patients would be extremely likely or likely to recommend the practice to their friends and family if they needed similar care or treatment.
- 7% of patients had no definitive view.
- 24% of patients would be extremely unlikely or unlikely to recommend the practice to their friends and family if they needed similar care or treatment.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice had received 46 complaints in the last year, these included:
 - Difficulties in making appointments
 - Accessing care in a timely manner
 - Prescriptions
 - We reviewed a number of these complaints and found that they were handled in a consistent way and actions were in line with their own policies and procedures.
 - The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, a complaint highlighted inaccurate information given by a new member of

Are services responsive to people's needs?

(for example, to feedback?)

staff. In response to this we saw that the practice had investigated the complaint, made a full apology to the patient and had given additional training to new staff members to prevent a recurrence.

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 and all of the population groups good for providing a well-led service.

Leadership capacity and capability

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

- They were knowledgeable about issues and priorities relating to the quality and future of services. They clearly understood the challenges in relation to recruitment and retention of staff and were in the process of the implementation of measures to address them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff told us that they felt there was an “open door” management approach and that they felt comfortable raising issues with the partners and managers.

Vision and strategy

The practice had a clear vision to endeavour to provide the best possible health care to their patients in a professional environment that was easily accessible to all.

- The practice had a realistic strategic approach to identify challenges, and had developed action and delivery plans to help them meet their goals. For example the practice had devised an action plan to improve patient satisfaction.
- Staff were aware of and understood the vision and values, and their role in achieving them.
- The strategic approach and priorities were in line with health and social issues across the region. The practice could evidence how they planned their services to meet the needs of the practice population.
- The practice monitored progress against delivery of the key objectives.

Culture

The practice had a culture which aimed to provide high-quality care.

- Staff stated they felt respected, supported and valued. They informed us they liked to work in the practice.
- The practice focused on the needs of patients and had provided specific additional services to meet these needs.

- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing staff with the development they need. This included appraisal and career development conversations and we saw that staff had progress through the organisation. All staff had received an appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team and were given protected time for professional development.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.
- There were positive relationships between staff and teams.

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 and understood. 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 effective policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Where leaders had identified failings in their systems, they had developed action plans to remedy these. For example they had developed plans regarding recruitment and the development of staff in an attempt to improve access to the service for their patients.

Managing risks, issues and performance

Are services well-led?

Good 

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

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations and prescribing. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- There was only limited assurance that clinical audit had a positive impact on quality of care and outcomes for patients as those that had been completed lacked sufficient depth. There was however clear evidence of performance management and the tracking of key priorities.
- The practice had plans in place and had trained staff for major incidents. For example the practice had a comprehensive business continuity plan which had been recently tested when the practice suffered a serious leak from a burst water pipe. Feedback from the practice showed that the incident had been managed and that disruption to patients had been minimised.
- The practice implemented service developments and where efficiency changes were planned or had been made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice submitted data or notifications to external organisations as required.
- There were 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 the development of services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was a small but active patient participation group which we were told met on a monthly basis. Unfortunately members of the group were unable to speak with the inspection team on the day of our visit to the practice.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice sought to raise the awareness of patients with regard to the challenges faced by general practice and had produced a leaflet which highlighted these. This included some of the issues faced by the practice in relation to staffing, capacity and demand.
- We saw that staff meetings were held on a regular basis. It was however noted that there was only limited opportunity for all staff to attend these. Minutes were kept of these meetings which were available on the practice computer system.
- There was engagement and input into the wider health and care community with partners from the practice being actively involved in the local CCG and Federation.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- Although the practice had experienced capacity constraints it was able to evidence that continuous learning, improvement and innovation was supported within the practice. For example:
 - The practice worked with a local NHS Trust who provided a telemedicine service to two local nursing homes.
 - The practice participated in a trial of a late home visiting service whereby requests for home visits received from 1pm to 5pm were referred on to the community matrons who would then visit the patient and deal with their issues. This meant that if appropriate patients received visits that day rather than having to wait until the next day.

Are services well-led?

Good 

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

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.