Drs DP Diggle & RE Phillips

Inspection report

Church View Health Centre
Langthwaite Road
South Kirkby
West Yorkshire
WF9 3AP
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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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. The practice was previously inspected on 29 September 2015 and was rated as Good overall, with Outstanding for Caring.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Drs DP Diggle and RE Phillips on 12 April 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines, and supported this work with clinical audits and the analysis of outcomes and performance.
- Procedures for handling repeat prescriptions did not give full assurance that authorisation processes and review dates were fully in place.
- Services had been developed by the practice to meet the needs of the local population; this included an extensive diabetes service and the provision of a wound and burns dressing service.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw an area of outstanding practice:

- The practice had developed a range of responsive services and activities for patients with long-term conditions. Services and activities included:
  - The provision of an extensive diabetes service which demonstrated active management and support for patients.
  - The practice worked hard to improve patient awareness of long-term conditions and the need for screening. For example, the practice made extensive use of themed noticeboards which were regularly updated.
  - The practice sought to support long-term condition patients to make lifestyle changes to improve their wellbeing. They delivered weight management advice and loaned dietary books to patients.

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

- Review and improve reception staff knowledge with regard to patients attending the practice with possible symptoms of sepsis.
- Review and improve procedures for the review and authorisation of repeat prescriptions.
- Continue to review the implementation of the recently introduced new process for the monitoring of patients prescribed high risk medicines to ensure that it is effective.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector; the team also included a second CQC inspector and a GP specialist adviser.

Background to Drs DP Diggle & RE Phillips

The practice of Drs DP Diggle and RE Phillips is located at Church View Health Centre, Langthwaite Road, South Kirkby, West Yorkshire, WF9 3AP. It currently provides services for around 4,200 patients. The practice is a member of the NHS Wakefield Clinical Commissioning Group (CCG).

The practice is registered by CQC to carry out the following regulated activities, maternity and midwifery services, family planning services, treatment of disease, disorder or injury, surgical procedures, and diagnostic and screening procedures.

The practice operates from Church View Health Centre and is located on the first floor of a large purpose designed building which it shares with another GP practice and a number of other health and care providers. The building is accessible for those with mobility problems and a lift is provided to assist patients with access to the practice. The practice has on-site parking available for patients, with designated spaces for patients with limited mobility, or those patients who use a wheelchair.

The practice serves an area which was in the past linked predominantly to mining and associated industries. The practice has a high prevalence of long term conditions with 66% of patients reporting that they had a long standing health condition compared to the CCG average of 57% and the England average of 54%. The population age profile shows that it is comparable to the CCG and England averages for those over 65 years old (18% compared to the CCG average of 18% and England average of 17%). Average life expectancy for the practice population is 77 years for males and 81 years for females (CCG average is 78 years and 82 years respectively and the England average is 79 years and 83 years respectively). The practice serves some areas of higher than average deprivation being ranked as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice population is predominantly White British.

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

- childhood vaccination and immunisation
- Influenza and Pneumococcal immunisation
- Rotavirus and Shingles immunisation
- Minor surgery
- Learning disability support
- Minor surgery
- Pertussis vaccine for pregnant women
- Prostate cancer injection therapy
- Diabetes management

As well as these enhanced services the practice also offers additional services such as those supporting long term conditions management including asthma, chronic obstructive pulmonary disease, heart disease and hypertension.

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

The practice has two GP partners (one male, one female). In addition there is one specialist minor illness nurse, one specialist practitioner/nurse, two practice nurses and one healthcare assistant (all female). Clinical staff are supported by a practice manager, an assistant practice manager and an administration and reception team.

The practice appointments include:

- Pre-bookable appointments
- Urgent and on the day appointments
- Telephone consultations and telephone triage
- Home visits

Appointments can be made in person, via telephone or online.

Practice opening times are:

Monday to Friday 8am to 6.30pm. With extended evening opening on Tuesdays 6.30pm to 8.30pm.

Out of hours care and weekend appointments are provided by GP Care Wakefield and are accessible at two sites in the locality.

The previously awarded ratings are displayed as required in the practice and on the practice's website.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis. In the case of DBS checks, the practice made these checks on recruitment but would only make further checks when these were identified as being required.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. We were told by the practice that they had not had the need to use locum GPs for a period of five years.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- 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 including sepsis. However practice reception staff were not fully aware of the symptoms of possible sepsis to enable fast-tracking to appropriate care. Since the inspection we been assured that staff had been made fully aware of symptoms and the actions to take should these be identified.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- The practice had processes in place to receive and action medicines and patient safety alerts. We saw that safety alerts were solely being received by the practice manager who only worked three days per week at the practice. This did not give full assurance that safety alerts were being actioned in a timely manner as there could be a delay between receipt of an alert and subsequent assessment and action. We raised this with the practice who informed us that the assistant practice manager who worked five days per week would also register to receive alerts.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had systems in place for appropriate and safe handling of medicines. However some of these needed improvement or further embedding.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, generally minimised risks. However it was noted during the inspection that:

Good

Are services safe?

  - We were not fully assured with regard to practice processes for handling repeat prescriptions. In particular that authorisation processes and review dates were not in place in all cases. This could result in prescriptions being issued beyond the review date. The practice process placed a reliance on medication reviews being triggered by chronic disease reviews. The practice told us that they would examine this immediately.
  - The practice had recently introduced a new process for the monitoring of patients prescribed high risk medicines following the identification of concerns with regard to the operation of previous process. This had not yet been reported as a significant event; however we were told by the practice that this would be completed and that the new monitoring processes would continue to be embedded and were to be the subject of future clinical audit.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial management in line with local and national guidance. It was noted that prescribing rates for hypnotics (a class of psychoactive medication whose primary function is to induce sleep and to be used in the treatment of insomnia (medicines used to aid sleep) was significantly above local and national levels. We discussed this with the practice who told us that this was based on the historic needs of the local population. The practice offered a shared care drug service which attracted patients with drug dependencies to register at the practice; this cohort of patients often had coexistent hypnotic use. We saw recent unverified data which showed a reduction in hypnotic prescribing.
- There were effective protocols for verifying the identity of patients during telephone consultations.

Track record on safety

The practice had a good track record on safety.

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

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The practice had appointed a medicines safety champion. We saw that the identification of medicines related issues and subsequent recording had increased in the practice and in 2017/18 had exceeded their target. This showed effective recognition and transparency.
- 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.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

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' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- 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 including a review of medication.
- The practice operated a simple telephone system which allowed patients to access reception directly without the need to choose options. The practice told us that patients preferred and appreciated this approach and National GP patient survey results for accessibility supported this.
- Patients aged over 75 received health checks either opportunistically or as part of a review of their long-term conditions. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice actively encouraged participation in the annual flu vaccination programme and in 2017/18 achieved a vaccination rate of 78% of over 65s compared to a CCG average of 73% and a national average of 74%.

People with long-term conditions:

- The practice had developed an extensive diabetes service for patients led by the practice nurse specialist practitioner. At the time of inspection 327 patients with diabetes were registered (this equates to approximately 8% prevalence with 40 patients with Type 1 Diabetes and 287 patients with Type 2 Diabetes). In total the practice was independently responsible for the care of 305 patients living with diabetes. The service offered patients:
- Dedicated care planning; in 2017/18 the practice had 100% achievement for the eight care processes for diabetes against a local CCG service contract.
- The practice actively managed patients on insulin and this included insulin initiation (and also GLP-1 initiation and management, GLP-1is a medicine used to support diabetic patients). 90 patients were in receipt of insulin therapy, of which 13 attend the hospital diabetes service, nine received shared care between hospital and the practice and 68 were seen exclusively by the practice.
- Outcome data for 32 patients who had been supported with regard to diabetes and weight management showed that 30 patients had successful outcomes.
- Staff in the practice had developed resources such as pocket reference cards for other health professionals which gave concise information and advice.
- The practice raised diabetes awareness via noticeboards and participated in national awareness campaigns. Recently the practice had also written to over 100 patients at risk of diabetes to be more aware of symptoms and encouraging them to participate in diabetes programmes.
- The lead nurse actively shared her experiences and expertise in the field with others and we saw evidence of lectures and training she had delivered and of journal articles she had produced.
- We also saw evidence of testimonials of patients who had been supported by the diabetes services delivered in the practice.
- Patients with long-term conditions had a structured annual review to check their health and medicines

needs were being met. For patients with the most complex needs, the lead clinician worked with other health and care professionals to deliver a coordinated package of care. Annual reviews were 30 to 40 minutes long in duration, and those with multiple conditions could have reviews carried out on all their conditions at one appointment.

- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were consistently above the target percentage of 90%. We were told by the practice that this performance was achieved through active engagement with parents and close liaison with health visitors.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 72%, which was below the 80% coverage target for the national screening programme. However this performance was comparable to the CCG average of 75% and the national average of 72%. The practice told us that they were aware of their current performance and sought to increase levels of screening through raising awareness amongst target patients and via the provision of late evening smear clinics. The practice also told us that they had regular contact with patients who had missed screening appointments.
- The practices' uptake for breast and bowel cancer screening was generally in line the national average. The practice clinical system had prompts on the patient record in relation to bowel cancer screening and we saw that leaflets in the waiting area publicised screening.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- 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.
- The practice offered an electronic prescription service; recent data showed 68% of prescriptions were issued by the practice this way.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held registers of patients living in vulnerable circumstances this included those with a learning disability and patients living with dementia.
- Patients with a learning disability could access annual health checks. In 2017/18, 83% of these patients had received a health check.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 97% 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%.

Good

Are services effective?

- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was above the CCG average of 92% and the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was above the CCG average of 92% and the national average of 91%.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The dementia diagnosis rate was 78% and was already above the local target of 72% and the national target of 67% set for 2018/19.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example the practice had carried out a number of clinical audits in the previous two years such as recent audits on spirometry, specialist infant formulae and outstanding referrals. Where appropriate, clinicians took part in local and national improvement initiatives.

- Performance in relation to long-term conditions generally showed the practice was either comparable or above others it did show high performance in relation to care of patients with mental health, asthma and diabetes. For example, 94% of patients with diabetes on the practice register, had a last measured total cholesterol level (measured within the preceding 12 months) of 5 mmol/l or less compared to a CCG average of 83% and a national average of 80%.
- The practice used information about care and treatment to make improvements. For example, we saw that since the previous inspection in 2015 the practice had sought to reduce antibiotic prescribing. The practice had reviewed patients on long-term prophylaxis, reduced the threshold for prescribing such items and raised awareness amongst patients of the issue. Over this period the practice had reduced such prescribing by 28%. We saw similar evidence for reducing inappropriate prescribing for urinary tract infections and reducing opioid prescribing.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They

shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who may be vulnerable and those who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. In addition patients were able to access 24 hour blood pressure monitors and an electrocardiogram monitor.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. Despite the loss of local funding the practice continued to offer a weight management service to patients either on an opportunistic basis or if linked to a long-term condition.
- The practice made extensive use of displays to promote health messages, these displays and noticeboards were themed and changed on a regular basis.

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.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Results in relation to the national GP patient survey were consistently high for questions in relation to the caring attitude of staff. As an example, 91% of patients found receptionists helpful as compared to the CCG average of 86% and the national average of 87%.
- The practice had raised funds for numerous charitable organisations through activities such as raffles, and Christmas jumper days.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- The practice had appointed a member of staff to act in an asylum seekers liaison role. For example, activities included the arrangement of interpretation support and the identification of any other specific patient needs both pre and post consultation.
- The practice had received dementia friendly and young person accreditation for the services on offer at the practice. For example, staff at the practice were aware of the additional needs and support requirements of patients with dementia, and information for young people on the website was seen as being readily accessible.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them. They had organised and delivered a carers rights day event in November 2017 in conjunction with a local carers group. Support workers were available on the day and patients were offered information and advice.
- Patients reported being involved in decisions. As an indication of this 90% of patients reported that the last nurse they spoke to was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- 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.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services except for the long-term condition population group which was rated outstanding.

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Online services were available to patients such as booking appointments and repeat prescription ordering.
- When the established community services led wound dressing clinic ceased the practice gave additional training to staff which allowed them to delivered advanced wound dressing. Recently staff had identified that the wound service could be enhanced by extending this to include burns care. Staff had again received higher level training to deliver this specialist care and had purchased burns dressings and equipment.

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.
- Practice nurses and the health care assistant made visits to individual care homes to help support patients with chronic conditions.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice hosted abdominal aortic aneurysm screening (a way of checking if there's a bulge or swelling in the aorta, the main blood vessel that runs from the heart down through the body). Between 2012 and 2017 110 patients had attended for screening with three aneurysms being detected. In 2018 invitation letters for screening were personalised from their GP as a way of increasing attendance.
- Receptionists were trained as care navigators and were able to utilise an electronic referral template to arrange support for elderly and/or housebound patients from local organisations.

People with long-term conditions:

This population group was rated outstanding for responsive services because:

- The practice had actively developed new and responsive approaches to managing long-term conditions such as via a pulmonary rehabilitation group session and via patient awareness raising of conditions. In addition the practice had developed an extensive diabetes services to specifically meet the needs of the local population. Services had been designed to meet local patient need and included:

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  - Advanced care planning and the management of complex cases.
  - Access to secondary care specialists via e-consultations.
  - Development of a range of resources to raise awareness of diabetic issues and to support patients. This included weight management support and access to dietary books on loan from the practice.
  - Sharing training and other developments with other health professionals.

In addition:

- Reviews were carried out at extended appointments and we were informed by patients that they were fully involved in these reviews and actively supported by staff.
- The practice identified a need for a patient pulmonary rehabilitation group session. This was held in late 2016 and offered patients the opportunity to meet as a group and receive appropriate support for their condition. We were told feedback from patients was very positive with regard to participation in this group support session.

Good

Are services responsive to people's needs?

- Many noticeboards were themed to support patients with long-term conditions. For example in February 2018 the practice had developed a display to explain chronic kidney disease (a condition characterised by a gradual loss of kidney function over time).
- Patients with a long-term condition received an annual (or more frequent) 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. Review performance within the practice was high, and either comparable to or above local and national averages.
- Reviews were carried out at extended appointments and we were informed by patients that they had results and changes in their condition fully explained to them by staff.
- The practice held regular meetings with the local health and care professionals to discuss and manage the needs of patients with complex medical issues.
- The practice hosted a number of services which supported patients closer to home. These included services in relation to nephrology (a branch of medicine concerned with the treatment of disorders and diseases of the kidneys).

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary. Overall the practice told us it was their ethos never to willingly turn any patient away.
- One of the GP partners led on women's health issues and coordinated service such as family planning and sexual health. The practice offered a range of contraceptive options which included contraceptive injections and implants. In addition the practice operated as a distribution centre which offered free condoms to young people aged 13 to 25.
- The practice offered HPV (human papillomavirus) vaccinations and was also able to signpost patients to sexual health clinic which operated in the same building.
- The practice ran a weekly baby vaccination clinic.
- The practice in 2017 had been inspected and awarded the "Youth Approved Customer Service" Award. Feedback from young people was very positive and they found the website accessible.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered extended opening hours on a Tuesday evening.
- Telephone consultations were available for patients who were unable to attend the practice during usual opening hours.
- Patients were actively encouraged to register for online services and at the time of inspection 25% of patients had registered (an increase from 20% in April 2017). The practice had also invested time to develop their website which was very clear and informative, and in March 2018 had received 3,410 unique visits.
- The practice hosted a number of services which could benefit this population group, these included:
  - Physiotherapy
  - Ultrasound
  - Counselling
  - Musculoskeletal services

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances which included asylum seekers and those with a learning disability.
- The practice had appointed a member of staff to act as a named liaison for asylum seeker families and the role supported their interactions with these families. Support included ensuring appropriate access to the service such as pre-booking interpreters.
- Due to the number of Polish families living in the locality the practice arrival screen could be accessed in Polish and a number of key documents had been translated.
- One member of staff had completed level one training in British Sign Language.
- People in vulnerable circumstances were easily able to register with the practice and were supported by the practice to do this.

Good

Are services responsive to people's needs?

- The practice was a member of Wakefield Council's Safer Places Scheme. This provided a safe haven for those within the community that were vulnerable and who may need help and assistance outside their home environment.
- One of the partners had developed a long-standing relationship with the local drugs treatment service and through this the practice has delivered a shared care drugs clinic over a number of years. The practice also hosted a Hepatitis C clinic.

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

- The practice was registered as a dementia friendly organisation and had made adaptions to the building such as revised signage and seating to support dementia patients. Staff we spoke to had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice hosted a dedicated mental health clinic.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.

National GP patient survey results showed that the majority of patients found the practice accessible. Results were consistently above local and national averages. For example, 81% of patients usually get to speak with their preferred GP compared to a CCG average of 44% and a national average of 56%.

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. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were generally in line with recognised guidance. 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.

However we noted that:

- When we examined an example of complaint correspondence this did not contain reference as to who the patient could escalate their complaint to if dissatisfied with the practice response. Since this was raised with the practice they have told us that this will be included in future correspondence with complainants.
- At the time of inspection only written formal complaints were being recorded by the practice. This meant that any retrospective review and trend analysis of complaints would only be limited to formal complaints and that as a result potential learning could be limited.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop capacity and skills. The practice had recognised the challenge of an ageing workforce within their own stable staff structure, and had implemented some preliminary actions to reduce the impact due to possible staff retirement. This included training and developing staff to deliver services in new areas of work.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic approach and supporting plans to achieve priorities. The practice had developed its vision and values over time, and drew on their own experiences and the needs of their patient population when it adopted this approach.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of quality, sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice, and felt that the whole practice worked closely together.
- The practice focused on the needs of patients and had developed services to meet identified need. For example, after the previous community health wound dressing services ceased the practice developed their own service and had recently extended this service to include burns dressings.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. We saw a number of examples of staff career development and training, these included:
  - Two practice nurses had been supported to become prescribers.
  - A practice nurse had received training to allow them to take cervical smears.
  - Reception staff had received care navigation training.
  - The assistant practice manager had been supported to attain an advanced health service administration certificate.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams. Staff reported that all staff worked closely together and that there was mutual respect between team members.

Governance arrangements

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

Good

Are services well-led?

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

Managing risks, issues and performance

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

- There was generally an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. However we were not fully assured with regard to practice processes for handling repeat prescriptions. In particular that authorisation processes and review dates were not in place in all cases.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.
- The practice had a proactive view to performance and regularly analysed results and attainment. QOF performance for 2016/17 was 100% and clinical leads had been appointed for key areas of work and conditions. We saw that the management team took effective action with regard to areas of low performance and had put in place measures to drive improvement. For example, through a number of actions antibiotic prescribing had fallen by 28% between 2015 and 2018.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The practice had recently established a new virtual patient participation group. Members of the group were positive about their future role in the continued development of the practice.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. In addition a staff member from the practice shared their diabetes expertise at both a local and national level.

Good

Are services well-led?

- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared across the practice at meetings and was used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice was open to innovation and had adopted or developed new or extended services, these included:
  - The continued development and enhancement of services for patients with diabetes or patients at risk of developing diabetes
  - Wound and burns management
  - Pulmonary rehabilitation group session

Please refer to the Evidence Tables for further information.