

Dr N Chandra and Partners

Quality Report

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Date of inspection visit: 21 April 2016
Date of publication: 04/08/2016

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr N Chandra and Partners on 21 April 2016. Overall the practice is rated as outstanding.

Our key findings across all the areas we inspected were as follows:

- All staff were open, transparent and fully committed to reporting incidents and near misses. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning and personal reflection from internal and external incidents were maximised.
- The whole team was engaged in reviewing and improving safety and safeguarding systems. They used the Care Quality Commission fundamental standards to measure standards of care and signed up to the NHS England Sign up to Safety campaign.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local

providers to share best practice. For example, they developed practice specific protocols to safeguard patients, identify patients at risk of exploitation and assess patient need.

- Feedback from patients about their care was consistently and strongly positive.
- The practice carried out regular patient engagement and surveys, including surveys for children for whom they introduced specific survey forms.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs and reduced inequalities. For example, they worked with the local community support workers to create new practice specific literature in Urdu and European languages.
- Comprehensive information about the practice and services was made available to patients including a patients' charter and quarterly practice and patient group newsletter..
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from external stakeholders, patients and from the patient

Summary of findings

participation group. For example, the practice reserved child only appointments after school and increased the availability of urgent appointments as a result of PPG discussions.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was active review of complaints and how they were managed and responded to, and improvements are made as a result. People who use services were involved in the review. The practice had a mission statement and a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed. Staff, patients and external stakeholders were encouraged to contribute to the practice strategy to deliver this vision.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw several areas of outstanding practice:

- The practice was very responsive to the needs of minorities. They engaged with the local community to co-produce practice specific information in their own language, for example, Urdu, Hungarian and Polish and introduced specific survey forms for children. Hungarian patients had a 21% fail to attend (FTA) rate for new patient appointments. They worked with local community support workers to create new practice specific literature in these languages. After the introduction of these resources the FTA rate decreased significantly.

- The practice recognised problems locally with human trafficking. They consulted local authorities and national guidance. The information was discussed with staff to raise awareness and identify indicators of modern slavery. Bespoke protocols were developed to assess these patients upon registration and at subsequent appointments or if they failed to attend for appointments.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. For example, they invited dementia patients and family members to suggest how services could be improved, which they acted upon.
- The practice made significant efforts to identify and support carers. There was a named carers champion who worked with local organisations to support carers and attended local carers champion meetings and events. We saw a dedicated carers corner in the waiting area with up to date information and saw examples of the support offered to patients, carers and their families. Carers were given a direct practice telephone number to ring for support. A local carer support organisation had acknowledged the practice's proactive approach to carers. The practice was featured in the Carers Count newsletter shortly after the inspection. The practice had significantly increased the proportion of carers on their register as a result of this activity.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as outstanding for providing safe services.

- The practice had signed up to the NHS England national Sign up to Safety campaign. As a result they undertook additional training and produced practice specific protocols on the clinical system to improve incident reporting, identify, safeguard and support patients at risk.
- All staff were open, transparent and fully committed to reporting incidents and near misses. Staff were encouraged to raise concerns and report incidents and near misses through a no blame culture. The process prompted staff to personally reflect on incidents.
- The practice could evidence where patients affected by incidents were invited to work with the practice to improve services for patients. For example, a family member of a dementia patient was invited to contribute to the development of a practice dementia patient pathway.
- They had a dedicated practice safeguarding team. GPs and the carer's champion attended local safeguarding meetings and liaised with the local safeguarding leads to ensure patients at risk were supported.
- The practice noticed an increase in young, Eastern European patients registering with the practice. The practice were aware of examples of human trafficking locally and developed protocols to assess these patients.
- The practice appeared to use every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation.
- Practice development plans were themed on the year of safety. Information about safety was highly valued and was used to promote learning and improvement. The whole team was engaged in reviewing and improving safety and safeguarding systems. Staff members had signed pledges to put safety first and contributed to discussions to improve safety. As a result the practice carried out assessments of the locality and bespoke practice protocols were developed which linked to local and national guidance. For example, in response to evidence of local human trafficking and exploitation.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Outstanding



Summary of findings

- There was a clinical lead for infection control who undertook regular audits and provided hand hygiene training for other staff members. The nursing team carried out regular audits of the vaccine fridges. Action was taken to identify medication approaching expiry dates to be used before new stock.
- There were comprehensive business continuity plans. The practice discussed the plans with other occupiers of the building and included emergency contact numbers for staff, building managers and other services.

Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- The nurses had lead roles in the management of patients with long term conditions.
- Eighty eight per cent of patients with diabetes, on the register, had a record of a foot examination and risk classification (CCG average 89%, national average 88%).
- The practice identified a high prevalence of Chronic Obstructive Pulmonary Disease (COPD). Two nurses received additional training in spirometry to deliver local care to this group of patients. Spirometry is a test used to diagnose COPD. Data from 2014/15 showed that 88% of patients with COPD (diagnosed on or after 1 April 2011) had their diagnosis confirmed by post bronchodilator spirometry. The practice showed us data from March 2016 which showed this increased to 93%.
- Staff assessed needs and delivered care in line with current evidence based guidance. Clinical protocols were reviewed in response to new guidelines. For example, the practice carried out a review of patients with atrial fibrillation in response to new Oral Anticoagulant Therapy (NOAC) guidance for primary care. Patients were invited to attend the surgery to assess and discuss the initiation of new medication.
- The practice demonstrated quality improvement which included clinical audits.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of comprehensive appraisals and personal development plans for all staff which included discussion and staff contribution to the practice vision and strategy.

Good



Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. For example, health visitors, school nurses, local palliative care nurses and midwives.
- Patients at risk of hospital admission but not under the care of the community matron were referred to the CCG care co-ordinators. The practice worked with the care co-ordinator who liaised with NHS and social care services to ensure patients were supported.
- Clinical staff carried out alcohol brief intervention advice. They used AUDIT-C which is a recognised screening tool that can help identify persons who are hazardous drinkers or have active alcohol use disorders.
- The service hosted a shared care specialist drug and addiction service. The GPs and specialist nurse from the community service worked closely with other local support services and safeguarding teams to support patients' recovery and help them to regain their independence.

Are services caring?

The practice is rated as outstanding for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for many aspects of care. For example, 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- Feedback from patients about their care and treatment was consistently and strongly positive. We spoke with eight patients, received 56 comment cards and saw letters and cards of thanks which were all positive about the service.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. For example, they invited dementia patients and family members to suggest improvements and improve services. As a result staff had received additional dementia friendly training and dementia friendly signage and information was displayed.
- There was a named carers champion who worked with local organisations to support carers. There was a dedicated carers corner in the waiting area with up to date information. Vulnerable patients and carers were given a direct practice telephone number to ring for support. We saw examples of how the carers champion liaised with the local safeguarding team,

Outstanding



Summary of findings

carers' support organisations, social care and housing associations to identify support for patients and carers. We saw examples of how they worked on a one to one basis with patients and their carers.

- The practice invited a local carer support organisation into the practice in February 2016 to deliver carer awareness training and review the information and support available. We saw a letter from the organisation confirming that the practice had signed up to the Carers Count GP partnership working scheme and the practice was featured in the Carers Count newsletter shortly after the inspection to highlight good practice.
- The introduction of a carers champion and proactive efforts to identify carers led to an increase of carers recorded by the practice. The practice had 91 patients recorded as carers up to May 2015. The number of carers recorded increased by 162 to a total of 253 by April 2016 (3% of the patient list).
- Information for patients about the services available was easy to understand and accessible in different languages that met the needs of the local population. There was a quarterly practice and patient group newsletter. The practice produced information leaflets for patients including a welcome pack for new patients and a top tips guide to accessing services.
- We saw staff knew patients well and treated them with kindness and respect, and maintained patient and information confidentiality. Data showed 92% of patients found the receptionists at this surgery helpful (CCG average 85%, national average 87%).
- The practice developed a bereavement protocol to ensure support was provided to the families and other services and support groups involved in their care were made aware.

Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, they participated in the pilot of the CCG Clarity Project which aims to reduce the overall prescribing of benzodiazepines.
- The practice signed up to initiatives to improve services. For example, Sign up to Safety and the Dementia Action Alliance to drive improvements.

Outstanding



Summary of findings

- The practice hosted services which supported the local CCG care closer to home policy. For example, extended minor operations, 24 hour blood pressure monitoring, ECGs, spirometry and phlebotomy.
- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. The staff monitored the practice population. They identified that Romanian and Hungarian patients had a 21% fail to attend (FTA) rate for new patient appointments. They worked with local community support workers to create new practice specific literature in these languages. After the introduction of these resources the FTA rate decreased to 10%.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had reviewed the availability of appointments and recruited an advanced nurse practitioner to improve access.
- The practice had a dedicated 24 hour appointment cancellation line. Patients left a message to cancel their appointment. Staff checked the messages daily and contacted patients to rearrange their appointment. They used text messages to remind patients of appointments.
- There was active review of complaints and how they are managed and responded to, and improvements were made as a result. People who use services were involved in the review process. Information about how to complain was available in different languages and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- Staff raised concerns that patients often attended for travel vaccinations in the days immediately before they travelled. The practice developed specific vaccination information in English and Urdu. Staff linked with the local library and community centre to publicise the importance of accessing vaccinations in a timely way before travel.
- The practice responded to the high prevalence of Chronic Obstructive Pulmonary Disease (COPD). Two nurses received additional training in spirometry to deliver local care to this group of patients. Spirometry is a test used to diagnose COPD. Data from 2014/15 showed that 88% of patients with COPD

Summary of findings

(diagnosed on or after 1 April 2011) had their diagnosis confirmed by post bronchodilator spirometry. The practice showed us data from March 2016 which showed this increased to 93%.

Are services well-led?

The practice is rated as outstanding for being well-led.

- The practice had a mission statement and clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with staff and stakeholders. The mission statement and individual declarations of what the statement and work meant to all staff members were displayed prominently in the practice.
- Staff were encouraged to contribute to the vision, values and practice plan which were regularly reviewed and discussed with staff.
- A systematic approach was taken to working with other organisations to improve care outcomes and tackle health inequalities. For example, the practice engaged with local organisations to improve care for Eastern European patients, carers and patients with dementia.
- There were named clinical and non-clinical support leads for safeguarding, mental health carers and dementia.
- The practice developed a patient charter, practice specific and health information in languages that reflected the needs of the local population.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- The practice had comprehensive business continuity plans . The practice manager implemented learning from pandemic flu to ensure continuity of services.
- Staff appraisals were comprehensive and encouraged staff members to identify opportunities to develop their roles and improve patient services.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- Leaders strived to deliver and motivate staff to succeed. Many staff members told us how they had been encouraged to undertake further education, suggest ideas for and lead on areas of improvement.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement.

Outstanding



Summary of findings

- The practice had an engaged patient participation group which influenced practice development. The PPG met regularly and members told us the senior GP and practice manager always attended the meetings. The group actively encouraged new and diverse membership to reflect the local population and had recently recruited two new members.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- There was a strong focus on continuous learning and improvement at all levels.

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

The practice is rated as outstanding for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Flu vaccination rates for the over 65s were 79% compared to the national average of 73%.
- The percentage of older people attending for screening programmes was comparable to national averages. For example, 50% of patients aged 60-69, were screened for bowel cancer within 6 months of invitation compared to the national average of 52%.
- The practice reviewed patients aged over 75 with more than 10 medications on repeat prescriptions and reviews for patients over 75 without any long term conditions.
- Care home staff were issued with a dedicated telephone number for instant access when the surgery is open.
- The practice referred vulnerable older people to the Kirklees Carephone home safety service which provides assistive technology to help older people to live independently in their own home.
- Older people were signposted to use The Silver Line which is a free confidential helpline providing information, friendship and advice to older people, 24 hours a day.
- Data showed that 31% of older patients were affected by income deprivation. The carers champion helped them to identify sources of financial help and assisted them with completing application forms. Older people at risk of hospital admission but not under the care of the community matron were referred to the CCG care co-ordinators. The practice worked with and referred patients to a care co-ordinator who liaised with NHS and social care services to ensure patients were supported.

Outstanding



People with long term conditions

The practice is rated as outstanding for the care of people with long-term conditions.

Outstanding



Summary of findings

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Eighty eight per cent of patients with diabetes, on the register, had a record of a foot examination and risk classification (CCG average 89%, national average 88%).
- Longer appointments and home visits were available when needed.
- The practice identified a high prevalence of Chronic Obstructive Pulmonary Disease (COPD). Two nurses received additional training in spirometry to deliver local care to this group of patients which increased the number of patients who had their diagnosis confirmed.
- Patients at risk of hospital admission but not under the care of the community matron were referred to the CCG care co-ordinators. The practice worked with and referred patients to a care co-ordinator who liaised with NHS and social care services to ensure patients were supported.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Many Eastern European patients presented with poorly managed long term conditions. The practice used interpreters and produced patient information in other languages to encourage patients to manage their condition and attend for screening and review appointments.

Families, children and young people

The practice is rated as outstanding for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG and national average of 82%.

Outstanding



Summary of findings

- Appointments were available outside of school hours and a number of child only appointments were reserved after school hours.
- The premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice introduced specific patient survey forms for children.
- There was a practice safeguarding team and the practice developed systems to proactively identify children at risk. The team attended safeguarding meetings and met regularly with local safeguarding leads.

Working age people (including those recently retired and students)

The practice is rated as outstanding for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered late appointments on Tuesday and Wednesday evenings for working people.
- The practice had a dedicated 24 hour appointment cancellation line and used text messages to remind patients of appointments.
- Drop in phlebotomy and ECG services were provided five days a week.

Outstanding



People whose circumstances may make them vulnerable

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- Staff regularly worked with other health care professionals in the case management of vulnerable patients.

Outstanding



Summary of findings

- There was a named carers champion who worked with local support organisations to support carers. There was a dedicated carers corner in the waiting area with up to date information and carers were given a direct telephone number to ring for support.
- The introduction of a carers champion and proactive efforts to identify carers lead to an increase of carers recorded by the practice. The practice had 91 patients recorded as carers up to May 2015. The number of carers recorded increased by 162 to a total of 253 by April 2016 (3% of the patient list).
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff liaised with local support groups and ensured that information given to patients was up to date.
- The practice had a dedicated safeguarding team who met with the local safeguarding teams regularly. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The service hosted a shared care specialist drug and addiction service. The GPs and specialist nurse from the community service worked closely with other local support services and safeguarding teams to support patients' recovery and help them to regain their independence.
- The practice was registered with the Kirklees Safe Places scheme. The scheme helps vulnerable people who become confused, frightened or need help when they left their homes.

People experiencing poor mental health (including people with dementia)

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

- 90% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average of 84%.
- 95% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months (CCG average 89%, national average 88%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Outstanding



Summary of findings

- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- They invited dementia patients and family members to suggest improvements and improve services. As a result staff had received additional dementia friendly training and dementia friendly signage and information was introduced.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- There were clinical and non clinical leads identified for dementia and mental health. Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice encouraged carers and family members to the West Yorkshire Police Herbert Protocol scheme which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in January 2016. The results showed the practice was performing above local and national averages for the majority of indicators. 300 survey forms were distributed and 111 were returned giving a response rate of 37%. This represented 1% of the practice's patient list.

- 74% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 91% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 77% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 56 comment cards which were all positive about the standard of care received. Comments included that all staff treated patients with care, dignity and respect. Many stated that staff were always helpful and tried to arrange appointments to suit patients. Several patients said that communication was excellent between staff and patients. Fourteen patients gave examples of where the practice and named staff members had cared for and supported them through tests and treatment.

We spoke with eight patients during the inspection. All eight patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Six of the patients were aware of the PPG. Three patients said they had been asked how the practice could improve services by completing a survey or completing a suggestion form.

Results from the 2015 NHS Friends and Family Test showed that of 69 responses, 64 patients were extremely likely or likely to recommend the practice to a friend or family member.

Outstanding practice

We saw several areas of outstanding practice:

- The practice was very responsive to the needs of minorities. They engaged with the local community to co-produce practice specific information in their own language, for example, Urdu, Hungarian and Polish and introduced specific survey forms for children. Hungarian patients had a 21% fail to attend (FTA) rate for new patient appointments. They worked with local community support workers to create new practice specific literature in these languages. After the introduction of these resources the FTA rate decreased significantly.
- The practice recognised problems locally with human trafficking. They consulted local authorities and national guidance. The information was discussed with staff to raise awareness and identify indicators of

modern slavery. Bespoke protocols were developed to assess these patients upon registration and at subsequent appointments or if they failed to attend for appointments.

- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. For example, they invited dementia patients and family members to suggest how services could be improved, which they acted upon.
- The practice made significant efforts to identify and support carers. There was a named carers champion who worked with local organisations to support carers and attended local carers champion meetings and events. We saw a dedicated carers corner in the waiting area with up to date information and saw examples of the support offered to patients, carers and their families. Carers were given a direct practice telephone number to ring for support. A local carer

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support organisation had acknowledged the practice's proactive approach to carers. The practice was

featured in the Carers Count newsletter shortly after the inspection. The practice had significantly increased the proportion of carers on their register as a result of this activity.

Dr N Chandra and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a practice nurse specialist adviser and an Expert by Experience.

Background to Dr N Chandra and Partners

Dr N Chandra and Partners provide primary care services to 8343 patients in the Ravensthorpe area of Dewsbury under a Personal Medical Services (PMS) contract. The practice is known locally as North Road Suite.

- The area is on the second decile on the scale of deprivation. Twenty eight per cent of patients are from Black Minority Ethnic populations, 5% of the patient population are from Eastern European populations and 6% of patients claim disability living allowance. Thirty two per cent of older people were affected by Income Deprivation (national average 16%). The area is affected by high levels of unemployment, 13% compared with the national average of 5%.
- The practice is located on the first floor of Ravensthorpe Health Centre which hosts another GP practice as well as health visitors, midwives and a dental surgery. The practice has car parking and is fully accessible to wheelchair users. A lift is installed to provide access to all floors.
- There are three GP partners, two male and one female, the practice also has a male GP who works on a sessional basis, a female advanced nurse practitioner,

four female practice nurses, three healthcare assistants, a female phlebotomist and a team of administrative staff. The practice merged with a single handed GP in 2014 who retired.

- The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 8.05am to 11.40am every weekday morning and from 4pm to 6.20pm Mondays, Wednesdays, Thursdays and Fridays. Extended hours appointments are offered on Tuesdays and Wednesdays from 3.40pm to 7.20pm.
- When the practice is closed, out-of-hours services are provided by Local Care Direct, which can be accessed via the surgery telephone number or by calling the NHS 111 service.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 April 2016. During our visit we:

Detailed findings

- Spoke with a range of staff including GPs, nurses, healthcare assistants and administrative staff.
- We spoke with the patient participation group and patients who used the service.
- Observed how staff interacted with patients in the reception and waiting areas and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

- Is it well-led?

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

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

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



Are services safe?

Our findings

Safe track record and learning

The practice signed up to the NHS England 2014 Sign up to Safety national campaign which aims to reduce avoidable harm in the NHS over the next three years. There was a safety improvement practice plan for 2016/17 themed on the year of safety. They created a five step pledge which included the areas of dementia, safeguarding, safe places and listening to patients, carers and staff, learning from what they say and taking action when things go wrong. We saw many of these actions identified in the practice plan had been implemented. For example, the development and implementation of bespoke templates and protocols for safeguarding, chaperoning, to assess mental capacity and to identify patients at risk. Staff members had signed pledges to put safety first and contributed to discussions to improve safety. These and information about the practice pledge were clearly displayed to patients in the waiting area.

There was an effective system in place for reporting and recording significant events.

- Staff told us they were encouraged to raise concerns and report incidents and near misses through a no blame culture.
- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) and we saw evidence that this had been followed.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, offered a face to face meeting with the senior GP, received reasonable support, truthful information, a verbal and written apology and were told about any learning from the incident including actions to improve processes to prevent the same thing happening again.
- The practice could evidence where people affected by incidents were invited to work with the practice to improve services for patients. For example, a family

member of a person with dementia was invited to contribute to the development of the practice dementia patient pathway. As a result of patient engagement the practice improved signage for patients with dementia.

- The practice carried out a thorough analysis of significant events and the practice could evidence that these were discussed with staff in regular meetings.
- GPs and staff recorded personal reflections from incidents involving them which were discussed at staff appraisals.
- The practice fed incidents into the North Kirklees CCG quality issues log and the National Reporting and Learning System (NRLS).

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a protocol was implemented to clarify staff roles and responsibilities for repeat prescribing in response to a medication error.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies and bespoke protocols were created which included links to local and national guidance and staff showed us how they accessed them on the clinical system and in the shared area of the IT system. These clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a practice safeguarding team with a lead GP for safeguarding who was trained to safeguarding level four. The GPs attended safeguarding meetings and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Other GPs and nurses were trained to safeguarding level three. The reception supervisor and practice development manager supported the safeguarding team and attended safeguarding meetings with the GPs. They met regularly with and provided an



Are services safe?

annual report to the local safeguarding nurse.

Safeguarding information for patients was included in the practice newsletter and displayed in the waiting room.

- The practice noticed an increase in young Eastern European patients registering with the practice. Staff were aware of examples of human trafficking locally. They consulted local authorities and national guidance. The information was discussed with staff to raise awareness and identify indicators of modern slavery. Bespoke protocols were developed to assess these patients upon registration and at subsequent appointments or if they failed to attend for appointments. We saw information about help for victims of modern slavery was available to patients in English, Polish, Hungarian, Lithuanian and Romanian languages.
- A notice in the waiting room advised patients that chaperones were available if required. We saw evidence that all staff who acted as chaperones were trained for the role. The practice development manager told us that staff were not permitted to chaperone until training had been undertaken and their Disclosure and Barring Service (DBS) check received. (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). Bespoke protocols which linked to national guidance and included practice procedures for recording chaperoning were created on the clinical system.
- All staff members had received a DBS check. The practice implemented a risk assessment tool for existing staff members and staff who joined during the practice merger to document their assessment of whether a DBS check was necessary.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and we saw evidence that staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice had a

programme of infection prevention training. For example, staff had received additional hand hygiene training and a further training session was booked for specimen sample testing.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines and vaccine storage audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. The practice received regular medicines management bulletins which were circulated to staff.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- The practice was registered with the Kirklees Safe Places scheme. The scheme helps vulnerable people who become confused, frightened or need help when they left their homes. Information about the service was clearly displayed around the practice. We saw evidence that the practice was one of the first venues to join the scheme. They invited a local mental health charity to deliver training for staff to assist people with dementia, learning disabilities or autism.

Monitoring risks to patients

Risks to patients were assessed and well managed.



Are services safe?

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and an evacuation chair was recently replaced as a result. Staff were trained as fire marshals and practiced regular fire drills and evacuation plans. Fire safety clipboards were wall mounted to ensure staff had quick access to building plans, zones and locations of extinguishers and oxygen tanks. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The building had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice development manager liaised with the building manager and other occupiers of the building to ensure that risks were identified and well managed.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had analysed demand and capacity to identify busy periods at the reception desk and on the telephone. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice learned from previous experience of pandemic flu to ensure the continuity of services. For example, administrative staff rotated to ensure they knew the different roles.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and practiced emergency scenarios on the premises.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. A member of staff was responsible for checking these regularly. All the medicines we checked were in date and stored securely.
- The practice had engaged with planning officers at the local authority to produce a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The practice discussed the plans with other occupiers of the building and included emergency contact numbers for staff, building managers and other services. We saw evidence that the plan had been followed effectively when the building experienced a complete failure of the telephone and email system.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through the development of practice protocols, risk assessments, audits and random sample checks of patient records.
- Minutes from staff meetings showed that NICE guidelines were discussed and reviewed following incidents and complaints.
- A healthcare assistant showed us how they use NICE guidelines and protocols for tasks including blood pressure checks.
- The practice carried out a review of patients with atrial fibrillation in response to new Oral Anticoagulant Therapy (NOAC) guidance for primary care. Patients were invited to attend the surgery to assess and discuss the initiation of new medication. Twenty-eight patients were reviewed by the GPs and after explicit informed consent & discussion agreed to start on one of the new NOAC medications. Nine patients declined to start any new agent and were happy with their use of aspirin.
- The practice identified that eastern European patients often registered with no medical history or immunisation record. The clinical team discussed these cases to agree care plans and ensured that children were immunised as appropriate. Many of these patients presented with poorly managed long term conditions. The practice used interpreters and ensured that patient information was available in other languages to encourage patients to attend for screening, manage their condition and attend review appointments.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for

patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96% of the total number of points available with 5% exception reporting. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

This practice was an outlier for two national clinical targets, hypnotics and antimicrobial prescribing. We saw evidence from the medicines management lead at the local CCG that the practice fully engaged with locally recommended initiatives designed to reduce prescribing of these medications, particularly the 2015 local antimicrobial resistance communication campaign. Data showed the average daily quantity of hypnotics prescribed per specific therapeutic group was 0.72 (national average 0.26) which was an improvement of 10% from the previous year. The number of antibacterial prescription items prescribed per specific therapeutic group was 0.46 (national average 0.27) which was an improvement of 9% from the previous year. The practice continued to work with the local medicines management team to improve prescribing.

Data from 2014/15 showed:

- 16% of the patient list were on the register for hypertension (national average 14%). Data showed that the last blood pressure reading was within normal parameters for 82% of these patients (CCG average 85%, national average 84%). Ninety four per cent of patients aged 45 or over had a record of blood pressure in the preceding five years (national average 91%).
- There was a clinical lead for mental health. Performance for mental health related indicators was better than the national average. Ninety five per cent of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months (CCG average 89%, national average 88%). Staff had additional training to understand the needs of patients with dementia. Two members of staff were identified as dementia champions who liaised with members of the Patient Participation Group who ran a local support group for patients with dementia.
- The practice identified a high prevalence of Chronic Obstructive Pulmonary Disease (COPD). Two nurses received additional training in spirometry to deliver

Are services effective?

(for example, treatment is effective)

local care to this group of patients, one of whom achieved the level three full certificate in spirometry to deliver spirometry at an advanced level. Spirometry is a test used to diagnose COPD. Data from 2014/15 showed that 88% of patients with COPD (diagnosed on or after 1 April 2011) had their diagnosis confirmed by post bronchodilator spirometry. The practice showed us data from March 2016 which showed this had increased to 93%.

The practice provided management and care for diabetic patients on insulin and injectable therapy which avoided unnecessary referral to secondary care at the hospital. Data showed that all patients newly diagnosed with diabetes, in the preceding 12 months had a record of being referred to a structured education programme within 9 months after entry on to the register with 73% exception reporting (CCG average 39%, national average 27%). The practice nurse told us that patients were referred to and encouraged to attend the local DESMOND programme (the DESMOND Programme offers training and quality assurance for Healthcare Professionals and Lay Educators to deliver modules and toolkits to people in their local communities). However, many patients refused to attend which resulted in the high exception rate. Staff managed the care of patients with diabetes in house. Patients were provided with up to date self-care advice and information. For example, 90% of patients diagnosed with dementia had been reviewed in a face-to-face review in the preceding 12 months compared with the national average of 84%. Eighty eight per cent of patients with diabetes, on the register, had a record of a foot examination and risk classification (CCG average 89%, national average 88%).

There was evidence of quality improvement including clinical audit.

- Examples included five clinical audits completed in the last two years. Two of these were completed audits where the improvements made were implemented and monitored and three were mid cycle.
- The practice participated in local audits, pilots, national benchmarking, accreditation, peer review and research. For example, the senior partner was the local CCG cancer lead. They were leading a pilot for Faecal Calprotectin (FCP) testing. The practice had signed up to

be included in the pilot. FCP is a simple diagnostic test which can aid clinicians to more accurately identify those patients who have irritable bowel disease who may require urgent referral for specialist assessment.

- Findings were used by the practice to improve services. For example, recent action taken as a result included creating a template to record the provision of emergency contraception, encourage patients to use planned contraception and record the advice given. There were further plans to improve the template in collaboration with IT services and the local sexual health clinic.
- The nursing team carried out regular checks of the vaccine fridges. Action was taken to identify medicines approaching expiry dates to be used before new stock.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice used occupational health services for staff. We saw evidence that staff had been referred to the service and advice followed. For example, in response to a needlestick injury.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. For example, two nurses received spirometry training, one of whom achieved the level three full certificate in spirometry qualification to deliver spirometry at an advanced level. A healthcare assistant had received additional phlebotomy and wound care training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. For example, by attending peer group meetings, access to on line resources and discussion at clinical meetings in the practice.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice

Are services effective?

(for example, treatment is effective)

development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months. Staff were provided with pre-appraisal folders with information about practice key priorities and plans. They prepared personal objectives and were encouraged to identify training needs, areas for development and personal achievements in advance of the meeting. Staff told us the practice encouraged and supported them to undertake additional training and education.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. The practice development manager regularly reviewed the e-learning available to staff and encouraged staff to undertake training. A staff rota was used to maximise staff attendance to ensure training was undertaken as a full team where possible to encourage participation and discussion. The practice invited the sessional GP who attended team training where possible.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice used bespoke pop up notifications and protocols on the clinical system to alert staff to relevant information about patients.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice referred patients taking benzodiazepines to the North Kirklees Clarity project which provides a structured programme to reduce the overall prescribing of these medicines. Benzodiazepines are used to treat both anxiety and sleeping problems. Data showed that of 29 patients referred, 14 no longer required medicines and eight had reduced their dosage.

- Patients at risk of hospital admission but not under the care of the community matron were referred to the CCG care co-ordinators. The practice worked with and referred patients to a care co-ordinator who helped patients to manage their health and liaised with NHS and social care services to ensure patients were supported. The practice worked with a local community provider to identify children at risk of hospital admission and introduce support to reduce unplanned hospital admissions.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- The practice team received Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS) training in September 2015 and the practice development manager had sourced Mental Capacity Act prompt cards for staff. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff used a bespoke protocol on the clinical system to carry out and record assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Clinical staff carried out alcohol brief intervention advice. They used AUDIT-C which is a recognised screening tool that can help identify persons who are hazardous drinkers or have active alcohol use disorders. Data showed that from April 2015 to March 2016, 694 patients had been reviewed using the screening tool and a further 74 patients had received additional structured advice to reduce their alcohol consumption.
- The service hosted a shared care specialist drug and addiction service. The GPs and specialist nurse from the community service worked closely with other local support services and safeguarding teams to support patients' recovery and help them to regain their independence.
- The practice contacted patients who were smokers on an annual basis to record up to date smoking status and offer help and support to quit. The practice hosted a weekly evening smoking cessation provider for working patients and referred patients to other local support groups. Ninety one per cent of patients aged 15 or over who were recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months (national average 87%).

The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG and national

average of 82%. A practice nurse was the clinical lead for cervical smears. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example, 70% of females aged 50-70 were screened for breast cancer in the preceding 36 months which was comparable with the national average of 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 97% to 100% and five year olds from 92% to 97%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40-74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.



Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff knew patients well. They were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 56 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with nine members of the patient participation group (PPG), two of whom were new members. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was consistently above average in its patient satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.

- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also overwhelmingly positive and aligned with these views. We also saw that care plans were personalised.

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

- 94% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- The practice worked with the local community to co-produce practice specific information in Urdu, Polish and Hungarian.
- The practice produced information leaflets for patients including a welcome pack for new patients and top tips guide to accessing services. All information leaflets were available in easy read format.
- The practice and PPG co-produced a quarterly newsletter for patients.



Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

Information about support groups was also available on the practice website.

The practice encouraged patients to inform the practice if they were a carer. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 253 patients as carers (3% of the practice list).

- There was a named carers champion who worked with local organisations to support carers and attended local carers champion meetings and events.
- We saw a dedicated carers corner in the waiting area with up to date information and carers were given a direct practice telephone number to ring for support.
- They invited a local carer support organisation into the practice in February 2016 to deliver carer awareness training and review the information and support available. We saw a letter from the organisation confirming that the practice had signed up to the Carers Count GP partnership working scheme and congratulating them on their proactive approach to support carers. The practice was featured in the Carers Count newsletter shortly after the inspection to highlight their achievements.
- The number of carers recorded was 253 which was an 178% increase from 91 patients recorded as carers up to March 2015.
- The carers champion liaised with the local safeguarding team, carers' support organisations, social care and housing associations to identify support for patients and carers. We saw examples of how they worked on a one to one basis with patients and their carers to source resources which resulted in safe discharge from hospital and independent living. They identified temporary and permanent housing solutions for drug and alcohol dependent patients. Data showed that 31% of older patients were affected by income deprivation. The carers champion helped them to identify sources of financial help and assisted them with completing application forms. We saw letters and cards from patients and their families thanking them for their support.
- The practice created a dementia action plan. They identified four members of staff as named dementia champions. They worked with and signed up to the Dementia Action Alliance to assess the practice against dementia friendly criteria and invited dementia patients and family members to suggest improvements and improve services. As a result staff received additional dementia training and dementia friendly signage and information was displayed for patients and their carers. Staff were planning two practice events for dementia patients and carers with invited speakers.
- The practice developed a bereavement protocol to ensure support was provided and other services and support groups involved in their care were made aware. Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card with a helpful bereavement booklet sourced by the practice. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. They had also sourced a separate booklet for people affected by suicide.
- The practice also demonstrated its caring attitude to staff. They provided occupational health service support to staff when they joined the practice, when they were affected by illness and when they returned to work after ill health. We saw evidence that staff had been referred to the service and advice followed.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice hosted services which supported the local CCG care closer to home policy. For example, extended minor operations, 24 hour blood pressure monitoring, ECGs, spirometry and phlebotomy.

- Extended hours appointments were offered on Tuesdays and Wednesdays. Appointments were from 3.40pm to 7.20pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- A drop-in phlebotomy service was provided five days a week.
- The practice offered an open access walk-in ECG service. Patients were assessed by a GP, if an ECG was required the health care assistant performed the procedure immediately. The practice carried out 136 ECGs over the preceding six months. Twelve were referred for further investigations after reassuring the patients to reduce anxiety, two were transported to hospital by ambulance as the ECG findings showed possible Acute Coronary Syndrome and two were diagnosed with atrial fibrillation.
- Same day appointments were available for children and those patients with medical problems that require same day consultation and the practice responded to a request to increase the number of urgent appointments for children after school.
- The practice had a dedicated 24 hour appointment cancellation line and used text messages to remind patients of appointments.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately. Staff raised concerns that patients often attended for travel vaccinations in the days immediately before they travelled. The practice developed specific vaccination information in English and Urdu. Staff linked

with the local library and community centre to publicise the importance of accessing vaccinations in a timely way before travel. They also used patient champions to distribute information in the community. Early feedback from staff and patients was positive but this was a relatively new scheme and the practice were yet to see the impact.

- There were disabled facilities, a hearing loop and translation services available.
- The practice identified and encouraged patients to use a range of support services for older people, vulnerable people and carers. They requested and responded to feedback from patients and carers to improve services.
- The practice responded to the high prevalence of Chronic Obstructive Pulmonary Disease (COPD). Two nurses received additional training in spirometry to deliver local care to this group of patients. Spirometry is a test used to diagnose COPD. Data from 2014/15 showed that 88% of patients with COPD (diagnosed on or after 1 April 2011) had their diagnosis confirmed by post bronchodilator spirometry. The practice showed us data from March 2016 which showed this increased to 93%. The practice carried out a patient satisfaction survey for the spirometry service which demonstrated high levels of staff satisfaction.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.05am to 11.40am every weekday morning and from 4pm to 6.20pm Mondays, Wednesdays, Thursdays and Fridays. Extended hours appointments were offered on Tuesdays and Wednesdays from 3.40pm to 7.20pm. Shortly after the inspection the practice introduced extended opening from 7.30am on Mondays, Wednesdays and Fridays in response to patient feedback.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was better than local and national averages.

- 88% of patients were satisfied with the practice's opening hours compared to the national average of 75%.



Are services responsive to people's needs?

(for example, to feedback?)

- 74% of patients said they could get through easily to the practice by phone compared to the national average of 73%).
- Regular patient surveys were conducted in collaboration with the PPG. The practice recognised that telephone access was highlighted by patients. As a result the practice was working to significantly increase the number of patients who used online services. They increased the number of online appointments to keep pace with registrations.
- The practice monitored the practice population and noted a 40% increase in the registration of European patients from February to April 2016 compared with data from October to December 2015. They identified that Romanian and Hungarian patients had a 21% fail to attend (FTA) rate for new patient appointments. In response they worked with local community support workers to create new practice specific literature in these languages and monitored the effect. After the introduction of these resources the FTA rate decreased to 10%.
- The practice carried out a patient satisfaction survey for the in-house spirometry service. All 27 patients contacted were extremely satisfied or satisfied with the service.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Carers and care homes and vulnerable patients were provided with a direct access telephone number during normal opening hours. A GP contacted the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical

need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available in the practice information leaflet, on the website and displayed in the waiting room to help patients understand the complaints system.

We looked at nine complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaint. Lessons were learnt from individual concerns and complaints and these were shared with complainants. We saw evidence that the practice discussed complaints in staff meetings and carried out analysis of themes trends. Action was taken to as a result to improve the quality of care. For example, we saw evidence of face to face resolution meetings with complainants and discussions of shared care and communication in clinical meetings and with community based healthcare professionals. The practice developed a new patient information leaflet for the travel vaccination service in response to a complaint. The patient said the process was unclear once they had handed in their forms. The practice manager worked with the patient to clarify what patients would find helpful to develop the leaflet.

Are services well-led?

Outstanding



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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice was clear about the vision and the values evident in their work with patients at risk and reducing inequalities.

- The practice had a mission statement. Staff reflected upon the practice mission statement and values as part of the appraisal process. The mission statement and individual declarations of what the statement and work meant to all staff members were displayed prominently in the practice.
- Staff and the PPG had all contributed to the vision and values of the practice. Staff knew and understood the values.
- The practice produced a patient charter which described what patients should expect of staff and the service. This was available on the practice website and in the waiting room.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- The practice signed up to local and national initiatives. For example, the NHS England Sign up to Safety campaign and Dementia Action Alliance. As a result, bespoke practice systems and protocols were developed with the involvement of staff and external organisations. The practice invited dementia patients and carers to suggest improvements which they acted upon.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. There were named clinical leads and non-clinical support staff for safeguarding, mental health and dementia.
- Practice specific policies and protocols were implemented and were available to all staff. We saw evidence that practice policies and procedures were reviewed at regular intervals and in response to national and local guidance updates.

- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

Partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care and this was reflected in practice plans and the patient charter. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- There was strong collaboration and support across all staff and a common focus on improving quality of care

Are services well-led?

Outstanding



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

and people's experiences. We saw a large board in the office with practice priorities where staff were encouraged to contribute training and practice development ideas. Staff had made several suggestions including introducing a carer's newsletter, liaising with the local community centre to enable face to face interpretation services for Eastern European patients and developing a dementia support package.

- There were consistently high levels of constructive staff engagement and the practice supported staff to lead on key areas of responsibility. For example, the senior reception manager was encouraged and supported to be the carer's champion. The partners encouraged and supported them to proactively identify carers, resources, attend local meetings and provide ongoing support. Other staff members were identified as dementia champions.
- There were high levels of staff satisfaction. Staff told us they had been encouraged to contribute to the visions and objectives of the practice. Individual staff members spoke highly of the practice and gave examples of the practice supporting and encouraging them to undertake additional training and expand their roles. The practice ensured staff undertaking additional training had protected study time and mentorship.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

A systematic approach was taken to working with other organisations to improve care outcomes and tackle health inequalities. For example, the practice engaged with local community workers to improve care and the information available to Eastern European patients. The practice held patient open days and attended local community events. They invited external organisations into the practice and changed the strategy as a result. For example, as a result of consultation with local carer and dementia organisations, the practice created strategies to identify practice leads who drove improvements which included support for vulnerable patients, carers, and patients with dementia.

The practice had a very engaged patient participation group which influenced practice development. The PPG met regularly and members told us the senior GP and practice manager always attended the meetings. The group actively encouraged new and diverse membership to reflect the local population and had recently recruited two new members from the Black Minority Ethnic (BME) population. Members of the PPG were regularly active in the waiting room including on the day of the inspection. They acted as a signposting service for people in the waiting room and provided assistance with form filling and explaining practice processes. The members were visible in the practice during seasonal flu campaigns and held coffee mornings and drop in events for patients. The group co-produced the quarterly practice newsletter and had a dedicated noticeboard in the waiting area which included information about the group and minutes of meetings. The PPG contributed to patient surveys and submitted proposals for improvements to the practice management team. For example, the practice reserved child only appointments after school and increased the availability of urgent appointments as a result of PPG discussions. PPG members attended the local CCG patient meetings and recently engaged with a local hospital consultation, providing patients with hospital discharge and aftercare. A member of the PPG told us the practice had supported them to complete their doctoral degree.

- The practice had gathered feedback from patients through engagement events, general and service specific surveys and complaints received.
- The practice had gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt valued, involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and engaged with local partners to improve outcomes and reduce inequalities for patients in the area. Staff were engaged and encouraged to undertake further education and contribute to the vision and strategy.