Lindley Group Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	11

Detailed findings from this inspection

Our inspection team	12
Background to Lindley Group Practice	12
Why we carried out this inspection	12
How we carried out this inspection	12
Detailed findings	15

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lindley Group Practice on 25 October 2016. Overall the practice is rated as good for providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

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

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients' needs were assessed and care was planned and delivered following local and national care pathways and National Institute for Health and Care Excellence (NICE) guidance.
- There was good access to clinicians and patients said they generally found it easy to make an appointment. There was continuity of care and if urgent care was needed patients were seen on the same day as requested. In addition to appointments, the practice provided an open access clinic three mornings a week.
- The practice staff had a good understanding of the needs of their practice population and were flexible in their service delivery to meet patient demands. The practice continually audited patient demand for appointments. Locums were used occasionally to meet increased demand.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice sought views on how improvements could be made to the service, through the use of patient surveys, the NHS Friends and Family Test and engagement with patients and their local community.
- Risks to patients were assessed and well managed.
- The practice had an organised approach to working systems and processes. There was a signatory sheet for all policies to evidence that staff had seen them.
- There were effective safeguarding systems in place to protect patients and staff from abuse.
- The practice promoted a culture of openness and honesty. All staff were encouraged and supported to record any incidents using the electronic reporting system. There was evidence of good investigation, learning and sharing mechanisms in place.

Summary of findings

- There was a clear leadership structure, staff were aware of their roles and responsibilities and told us the GPs were accessible and supportive. There was evidence of an inclusive team approach to providing services and care for patients.
- Staff had a ‘mini-meeting’ every working day to discuss any issues or concerns within the practice
- Staff said they were proud to work at the practice and felt they delivered good quality service and care to patients.
- The practice complied 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.)

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?

Good

The practice is rated as good for providing safe services.

- Risks to patients were assessed and well managed
- There were systems in place for reporting and recording significant events. There was evidence of investigation, actions taken to improve safety in the practice and shared learning with staff.
- There was a nominated GP lead and deputy lead for safeguarding children and adults. Embedded systems and processes were in place to keep patients and staff safeguarded from abuse. We saw there was safeguarding information and contact details available for staff.
- There was evidence of engagement with other health and social care professionals regarding safeguarding concerns of adults and children.
- There were processes in place for safe management of medicines and the practice was supported by a local Clinical Commissioning Group (CCG) pharmacist.
- There were systems in place for checking that equipment was tested, calibrated and fit for purpose.
- There were regular checks and risk assessments undertaken, which included those relating to health and safety, such as infection prevention and control.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Staff had the skills, knowledge and experience to deliver effective care and treatment. They assessed the need of patients and delivered care in line with local pathways and national guidance.
- The practice was supported by the local CCG pharmacy team to ensure effective prescribing was undertaken.
- We saw evidence of appraisals and up to date training for staff.
- There was evidence of working with other health and social care professionals, such as the mental health team, to meet the range and complexity of patients' needs.
- Clinical audits were carried out which could demonstrate quality improvement.
- End of life care was delivered in a compassionate and coordinated way.

Summary of findings

- Services were provided to support the needs of the practice population, such as screening and vaccination programmes, health promotion and preventative care.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally in line with local and national averages.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice comparable to other practices for the majority of questions regarding the provision of care. Comments we received from patients on the day of inspection were very positive about their care.
- We observed that staff treated patients with kindness, dignity, respect and compassion. Patients' comments aligned with those observations.
- Although the practice had a large patient population, there was a good understanding of the needs of their patients. It was apparent when talking with both clinical and administrative staff during the inspection there was a genuine warm and supportive ethos within the practice. Comments made by patients supported this view, often citing them as being a 'family practice'.
- There was a variety of health information available for patients, relevant to the practice population, in formats they could understand.
- The practice maintained a register of those patients who were identified as a carer and offered additional support as needed.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice worked with Greater Huddersfield Clinical Commissioning Group (CCG) and other local practices to review the needs of their population.
- The practice had good facilities and was equipped to treat patients and meet their needs. However, the practice identified there were some issues regarding the building and capacity.
- National GP patient survey responses and comments made by patients indicated appointments were available when needed.
- The practice offered pre-bookable, same day and online appointments. They also provided extended hours appointments in the week and an open access clinic three mornings a week.

Summary of findings

- All patients requiring urgent care were seen on the same day as requested.
- Home visits and longer appointments were available for patients who were deemed to need them, for example housebound patients or those with complex conditions.
- The practice could evidence being responsive to demands on the appointment system. They audited demand and capacity and also booked locums when there were anticipated pressures in the appointment system.
- There was an accessible complaints system. Evidence showed the practice responded quickly to issues raised and learning was shared with staff.

Are services well-led?

Good

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

- There was a clear leadership structure and a vision and strategy to deliver high quality care and promote good outcomes for patients.
- There were safe and effective governance arrangements. These included the identification of risk, with policies and systems in place to minimise risk.
- The practice had an organised approach to working systems and processes.
- Policies were available to all staff as a paper copy, as not all policies were currently accessible via the practice computer system. There was a signatory sheet for all policies to evidence staff had seen them.
- The provider complied with the requirements of the duty of candour. There were systems in place for reporting notifiable safety incidents and sharing information with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from patients through engagement with patients and their patient reference group.
- The practice promoted a culture of openness and honesty. Staff were encouraged to raise concerns, provide feedback or suggest ideas regarding the delivery of services. There was a daily 'mini-meeting' where all staff attended, to discuss any issues or concerns within the practice
- There was evidence of an inclusive team approach to providing services and care for patients.
- Staff said they were proud to work at the practice and felt they delivered good, quality service and care to patients.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

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

- Proactive, responsive care was provided to meet the needs of the older people in its population.
- They offered rapid access appointments to those patients with enhanced needs and those who could not access the surgery due to ill health or frailty.
- Medication reviews were undertaken every six months.
- Registers of patients who were aged 75 and above and also the frail elderly were in place to ensure timely care and support were provided.
- The practice worked closely with other health and social care professionals, such as the district nursing team, to ensure housebound patients received the care and support they needed.
- The practice liaised several times a week with local nursing homes, where they had registered patients who resided there.
- At 77%, the uptake rate for influenza immunisation in the over 65s was higher than the CCG target of 75%.

People with long term conditions

Good

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

- The GPs and practice nurse both supported the management of long term conditions. Annual or six monthly reviews were undertaken to check patients' health care and treatment needs were being met. There was an effective system for the follow-up of non-compliant patients.
- The practice maintained a register of patients who were a high risk of an unplanned hospital admission. Care plans and support were in place for these patients.
- Clinicians liaised with the community matron regarding care, treatment and support of these patients, particularly those which were housebound.
- There were effective systems in place to support the recall of these patients for influenza and pneumococcal vaccinations.
- Pre-diabetes checks and chronic obstructive pulmonary disease screening were undertaken with those patients who were deemed most at risk of developing these conditions.

Summary of findings

- 94% of newly diagnosed diabetic patients had been referred to a structured education programme in the preceding 12 months (CCG average 91%, national average 90%).
- 69% of patients diagnosed with asthma had received an asthma review in the last 12 months (CCG average 78%, national average 75%).
- 98% of patients diagnosed with chronic obstructive pulmonary disease (COPD) had received a review in the last 12 months (CCG average 87%, national average 90%).
- The practice provided a musculoskeletal clinic once a week.

Families, children and young people

Good

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

- The practice worked with midwives, health visitors and school nurses to support the needs of this population group. For example, the provision of ante-natal, post-natal and child health surveillance clinics.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.
- Patients and staff told us children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Same day access was available for all children who required medical attention.
- Childhood immunisations were offered in line with the public health immunisation programme.
- Sexual health, contraceptive and cervical screening services were provided at the practice, which included coil fitting and implants.
- The practice promoted cancer screening programmes. For example, 87% of eligible patients had undergone cervical screening (CCG average 85%, national average 82%).

Working age people (including those recently retired and students)

Good

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

- The needs of these patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Summary of findings

- The practice provided extended hours appointments from 7.30am on weekdays, online booking of appointments and ordering of prescriptions.
- There was an open access clinic three mornings per week.
- During influenza vaccination season, the practice offered Saturday morning flu clinics.
- The practice offered a range of health promotion and screening that reflected the needs for this age group.
- Travel health advice and NHS travel vaccinations were available.

People whose circumstances may make them vulnerable

Good

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

- Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- We saw there was information available on how patients could access various local support groups and voluntary organisations.
- The practice had a register of patients who had a learning disability. There was a named nurse who supported the delivery of annual health reviews of those patients.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice regularly worked with multidisciplinary teams in the case management of people in this population group, for example the local mental health team.
- Patients and/or their carer were given information on how to access various support groups and voluntary organisations.
- 77% of patients diagnosed with dementia had received a face to face review of their care in the preceding 12 months (CCG average 85%, national average 84%).
- 74% of patients who had a complex mental health problem, such as schizophrenia, bipolar affective disorder and other psychoses, had received a review of their care in the preceding 12 months (CCG 90%, national 88%).

Summary of findings

- Patients who were at risk of developing dementia were screened and support provided as necessary.
- Staff had received dementia friendly training and could demonstrate a good understanding of how to support patients with dementia or mental health needs.

Summary of findings

What people who use the service say

The national GP patient survey distributed 221 survey forms of which 110 were returned. This was a response rate of 50% which represented 1% of the practice patient list. The results published in July 2016 showed the practice was performing in line with local CCG and national averages, for the majority of questions. For example:

- 90% of respondents described their overall experience of the practice as fairly or very good (CCG 87%, national 85%)
- 91% of respondents said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG 81%, national 79%)
- 69% of respondents described their experience of making an appointment as good (CCG 75%, national 73%)
- 85% of respondents said they found the receptionists at the practice helpful (CCG 88%, national 87%)
- 98% of respondents said they had confidence and trust in the last GP they saw or spoke to (CCG 97%, national 95%)
- 99% of respondents said they had confidence and trust in the last nurse they saw or spoke to (CCG 97%, national 97%)

As part of the inspection process we asked for Care Quality Commission (CQC) comment cards to be completed by patients. We received 40 comment cards, all of which were positive. However, four of the respondents commented they sometimes had difficulty getting an appointment but did praise the availability of the open access clinics. There were many comments about staff being helpful, caring, respectful and professional. Many cited the service they received as being excellent.

We spoke with 10 members of the patient reference group (PRG). They were all very positive about the staff and the practice. They gave us several examples to demonstrate how they had been cared for and treated as patients. An example was given where the practice had responded effectively in an incident where a patient had required urgent care. The term 'family practice' was often used by the patients to describe the practice. From a PRG perspective they felt they were listened to by the practice. The PRG members did highlight the issues and their concerns regarding the premises and felt it was no longer suitable for the number of patients registered at the practice and their needs. We were informed of the difficulties for wheelchair users and pushchair/prams in accessing some areas due to the internal structure of the building.

We also received a written testimonial from a member of the PRG, informing us of how the practice are proactive in meeting patient demands, the growth of the patient list and the challenges arising from that, and the positive impact of the open access clinic.

Lindley Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector with the support of GP specialist advisor.

Background to Lindley Group Practice

Lindley Group Practice is a member of the Greater Huddersfield Clinical Commissioning Group (CCG). Personal Medical Services (PMS) are provided under a contract with NHS England. The practice is also registered with the Care Quality Commission (CQC). They offer a range of enhanced services, which include:

- extended hours access
- improving patient online access
- delivering childhood, influenza and pneumococcal vaccinations
- facilitating timely diagnosis and support for people with dementia
- identification of patients with a learning disability and the offer of annual health checks
- identification of patients at a high risk of an unplanned admission and providing additional support as needed.

The practice is situated on the Western outskirts of Huddersfield city centre, at 62 Acre Street, Lindley, Huddersfield HD3 3DY, and is located near to Huddersfield Royal Infirmary and the accident and emergency department. The premises are leased from the acute trust. There is wheelchair access via the front entrance and a disabled toilet on the ground floor. Patient consulting rooms are on two floors and access is by a stairway. Patients who have difficulty in climbing stairs are seen in a downstairs consulting room. Car parking is available at the rear of the premises and there are spaces allocated for disabled parking near the front entrance. We were informed that due to the proximity of the car park to the hospital, accident and emergency department and outpatient department, some people attending those services often parked in the practice car park, due to it being free of charge. This was causing some problems for patients accessing the practice. The practice had previously approached those services to highlight the issues.

The building had originally been a detached house which was subsequently converted to a GP practice. The internal layout of the building could not be altered for structural reasons. As a result, there were some obstacles for wheelchair users and pushchairs/prams. The practice had identified the issues and discussed their concerns on several occasions with the CCG and were currently putting a business case forward for new premises.

The patient list size is currently 10,297 consisting of 4,801 males and 5,496 females. The ethnic origin of patients is predominantly white British with a small number of patients from mixed ethnic backgrounds. Patient demographics are variable compared to CCG and national averages. For example:

- 49% of patients have a long standing health condition (CCG 55%, national 54%)
- 71% of patients are in paid work or full-time education (CCG and national 61%)
- Less than 1% of patients are unemployed (CCG 7%, national 5%)
- The deprivation score overall is 17%, compared to 21% CCG and nationally

The practice monitors the patient list on a quarterly basis and informed us they have a turnover of patients due to the close proximity of the hospital. Some of the staff who work there register with the practice during their placements.

Detailed findings

Due to the increasing patient list size and limited capacity within the premises, the practice had made the decision (in consultation with the CCG) to request patients who lived outside of the catchment area to register at a practice nearer to their homes.

There are five GP partners and two salaried GPs (five female, two male). There are two practice nurses and a health care assistant, all of whom are female. The clinicians are supported by a practice manager and a team of administration and reception staff who oversee the day to day running of the practice. In addition there is a female musculoskeletal specialist GP who holds a clinic once a week at the practice.

Lindley Group Practice is a teaching and training practice. They are accredited to train qualified doctors to become GPs (registrars) and to support undergraduate medical students with clinical practice and theory teaching sessions.

The practice is open Monday to Friday 7.30am to 6.30pm (it closes at 6pm on Friday). Appointments can be pre-booked or made on the same day. There are open access clinics available Monday, Wednesday and Friday mornings. 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.

The practice has good working relationships with local health, social and third sector services to support provision of care for its patients. (The third sector includes a very diverse range of organisations including voluntary, community, tenants' and residents' groups.) Locally, they have close working links with five nursing homes and a residential setting for patients with learning disabilities. Regular visits are made by the clinicians to these sites.

We were informed by both staff and patients of the concerns regarding the premises due to the increasingly growing patient population.

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 and inspection programme. 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 that we hold about the practice and asked other organisations, such as NHS England and Greater Huddersfield CCG, to share what they knew about the practice. We reviewed the latest 2014/15 data from the Quality and Outcomes Framework (QOF) and the latest national GP patient survey results (July 2016). QOF is a voluntary incentive scheme for GP practices in the UK, which financially rewards practices for the management of some of the most common long term conditions. We also reviewed policies, procedures and other relevant information the practice provided before and during the day of inspection.

We carried out an announced inspection on 25 October 2016. During our visit we:

- Spoke with a range of staff, which included two GP partners, a medical student, a practice nurse, the practice manager, office manager and administration staff.
- Reviewed CQC comment cards and spoke with patients regarding the care they received and their opinion of the practice.
- Reviewed questionnaires given to reception/ administration staff and the practice nurse prior to the inspection.
- Reviewed a summary of feedback from third year medical students who had placements at the practice.
- Observed in the reception area how patients, carers and family members were treated.
- Looked at templates and information the practice used to deliver patient care and treatment plans.

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?

Detailed findings

- Is it well-led?

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

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

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting, recording and investigating significant events (SEAs).

- There was a strong culture of openness, transparency and honesty.
- Staff told us they would inform the practice manager of any incidents. There was an electronic incident recording form on the practice computer system. The SEAs were discussed at the partners' meeting, nurse meetings and administration meetings. We looked at some incidents in detail and saw there was good evidence of investigation, actions taken to improve safety in the practice and shared learning with staff. However, there was no review to identify if there were any themes or trends within the SEAs. The practice informed us they would review their processes in relation to this.
- The practice was aware of their wider duty to report incidents to external bodies such as Greater Huddersfield CCG and NHS England. This included the recording and reporting of notifiable incidents under the duty of candour.
- When there were unintended or unexpected safety incidents, we were informed patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- There was a system in place to ensure all safety alerts were cascaded to staff and actioned as appropriate. We saw evidence where alerts had been actioned. For example, in September an alert had been issued regarding kits used in cases of severe hypoglycaemia (low blood sugar levels) in diabetic patients. The practice had identified six patients who could be affected. They had contacted them and clarified that the kits were not relevant to those patients.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse. We saw evidence of:

- Arrangements which reflected relevant legislation and local requirements were in place to safeguard children and vulnerable adults from abuse. Policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. Staff had received training relevant to their role. We were informed of several examples which could demonstrate their understanding of safeguarding. A GP acted in the capacity of safeguarding lead for adults and children. There was also an identified deputy GP, both of whom had been trained to the appropriate level three. Although it was not possible for the GPs to attend external multi-agency safeguarding meetings, reports were always provided where necessary. Patients who were vulnerable or at risk of safeguarding were identified on their patient record to alert staff as appropriate. The health visitor regularly attended the practice and any child safeguarding issues or concerns were communicated to them. Referrals were made to other health and social care agencies as appropriate.
- A notice was displayed in the waiting room, consulting and treatment rooms, advising patients that a chaperone was available if required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS). (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.) It was recorded in the patient's record when a chaperone had been in attendance or had been refused.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was a nominated lead for infection prevention and control (IPC). All staff had received up to date training in IPC. We saw evidence that an IPC audit had taken place and action had been taken to address any improvements identified as a result. There was an IPC policy in place and the practice liaised with the local IPC team as necessary.
- There were arrangements in place for managing medicines and vaccinations to keep patients safe. These included obtaining, prescribing, recording, handling, storage and security. Processes were in place for handling repeat prescriptions which included the review

of high risk medicines. Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads and blank prescriptions were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines, in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) The health care assistant was trained to administer vaccines or medicines against a patient specific direction (PSD). (PSDs are written instructions for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.)

- There was evidence of daily recorded checks made of vaccine fridge temperatures; which had external and internal temperature recording devices. The practice currently undertook three monthly checks of emergency drugs and equipment, which included a stock check. As a result of the inspection, the practice stated they would start checking these on a monthly basis.
- There were systems in place to review blood results and tests for patients and contact them for follow up. These included ensuring results were received for all samples sent for the cervical screening programme. The practice also followed up women who were referred to secondary care services as a result of abnormal results.
- We reviewed two personnel files of the most recently recruited staff. We found appropriate recruitment checks had been undertaken prior to employment, in line with the practice recruitment policy, for example proof of identification, references, evidence of qualifications and DBS checks.

Monitoring risks to patients

The practice had procedures in place for assessing, monitoring and managing risks to patient and staff safety. We saw evidence of:

- Risk assessments to monitor the safety of the premises, such as the control of substances hazardous to health and legionella. (Legionella is a bacterium which can contaminate water systems in buildings.)
- A health and safety policy and an up to date fire risk assessment.
- All electrical and clinical equipment was regularly tested and calibrated to ensure the equipment was safe to use and in good working order.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Both clinical and non-clinical staff worked flexibly to cover any changes in demand, for example annual leave, sickness or seasonal. We were informed that in cases of high patient demand for appointments the services of a GP locum was used to support access to timely care.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. We saw:

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff were up to date with fire and basic life support training.
- There was a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were stored in a secure area which was easily accessible for staff. All the medicines and equipment we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place, which identified what should be done and who to contact in the event of a major incident, such as power failure or building damage.

Good

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. We saw evidence where latest guidance was discussed at clinical meetings.

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). Clinicians each had a lead for the different domains within QOF. The practice manager was responsible for co-ordinating the reporting processes.

At the time of inspection the most recent published results (2014/15) showed the practice had achieved 93% (CCG average 96%, national average 95%) of the total number of points available, with 4% exception reporting which was lower than the CCG average of 8% and the national average 9%. (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). Data showed:

- Performance for diabetes related indicators were comparable to CCG and national averages. For example, 88% of patients on the diabetes register had a recorded foot examination completed in the preceding 12 months (CCG 89% and national averages of 88%).
- Performance for mental health related indicators were below the CCG and national averages in some areas. For example, 66% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of blood pressure in the preceding 12 months (CCG average 90%, national average 90%).

The QOF figures were discussed with the practice, particularly around the lower than CCG average results for mental health. We saw evidence which showed an improvement had been made from achieving 74% in 2014/15 to achieving 84% in 2015/16 of the total number of points for mental health indicators. Although this was still below the CCG average of 92%, we were informed the practice were continually trying to improve the recall and review of these patients. (At the time of the report going to publication the 2015/16 data had been verified and published.)

The practice used clinical audit, peer review, local and national benchmarking to improve quality. We looked at two audits which had been undertaken in the preceding two years. An audit had been undertaken regarding a specific medicine which had a potential risk of a deep vein thrombosis (DVT: an obstruction of a blood vessel due to a clot) and whether information had been given to the patient regarding signs and symptoms The initial audit in 2015 had found that none of the 16 patients had a record in their notes that this information had been discussed, although the risks of developing a DVT had been discussed and recorded. The results were shared with the other clinicians to encourage them to discuss and document the information. A re-audit in 2016 showed there had been a significant improvement, where 16 out of 19 patients had a recorded discussion taking place. This information was again cascaded to all clinicians.

The practice had also undertaken prescribing audits in line with the quality improvement in practice programme. As a result they could evidence prescribing budget savings which had been reinvested within the practice, for example the purchase of consulting room couches and electrocardiogram equipment.

Effective staffing

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

- The learning and development needs of staff were identified through appraisals, meetings and reviews of practice performance and service delivery. The GP partners undertook all the appraisals with staff; all of whom had received an appraisal within the preceding

12 months. The GPs liaised with the practice manager and administration manager regarding staff performance and development. As a result the GPs had a good understanding and knowledge of their staff.
- Staff were supported to access e-learning, internal and external training. They were up to date with mandatory training which included safeguarding, fire procedures, infection prevention and control, basic life support and information governance awareness. The practice had an induction programme for newly appointed staff which also covered those topics.
- Staff who administered vaccines and the taking of samples for the cervical screening programme had received specific training, which included an assessment of competence. We were informed staff kept up to date of any changes by accessing online resources or guidance updates.
- The GPs were up to date with their revalidation and appraisal.
- The practice nurses were up to date with their nursing registration.

Coordinating patient care and information sharing

The practice had timely access to information needed, such as medical records, investigation and test results, to plan and deliver care and treatment for patients. They could evidence how they followed up patients who had an unplanned hospital admission or had attended accident and emergency (A&E); particularly children or those who were deemed to be vulnerable. These patients were discussed at the weekly clinical meeting and care provided as needed.

Staff worked with other health and social care services, such as the community matron, district nursing team and mental health services, to understand and meet the complexity of patients' needs and to assess and plan ongoing care and treatment. With the patient's consent, information was shared between services using a shared care record. We saw evidence that multidisciplinary team meetings, to discuss patients and clinical issues, took place on a weekly basis. It was not expected that staff outside of the practice, such as the district nurse, community matron, should attend every week.

Care plans were in place for those patients who had complex needs, were at a high risk of an unplanned hospital admission or had palliative care needs. These were reviewed and updated as needed. Information regarding end of life care was shared with out-of-hours services, to minimise any distress to the patient and/or family.

One of the GPs had delivered a presentation to secondary care services to support the transition of patients from primary to secondary care and back again. There had been a particular focus on improving communication between services regarding diagnostic tests and discharge planning.

Consent to care and treatment

Staff understood the relevant consent and decision-making requirements of legislation and guidance, such as the Mental Capacity Act 2005. Patients' consent to care and treatment was sought in line with these. Where a patient's mental capacity to provide consent was unclear, the GP or nurse assessed this and, where appropriate, recorded the outcome of the assessment.

When providing care and treatment for children 16 years or younger, assessments of capacity to consent were also carried out in line with relevant guidance, such as Gillick competency and Fraser guidelines. These are used to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We saw evidence that when a patient gave consent it was recorded in their notes. Where written consent was obtained, this was scanned and filed onto the patient's electronic record.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted those to relevant services. These included patients:

- who were in the last 12 months of their lives
- at risk of developing a long term condition
- required healthy lifestyle advice, such as dietary, smoking and alcohol cessation
- who acted in the capacity of a carer

We were informed (and saw evidence in some instances) that the practice:

- Had a member of staff who acted as 'cancer screening champion' and encouraged patients to attend national screening programmes for cervical, bowel and breast cancer. There was a policy to offer telephone reminders

Good

Are services effective?

(for example, treatment is effective)

for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice uptake rates were higher than CCG and national averages, for example:

Cervical screening in the preceding five years was 87% (CCG 79%, national 82%).

Breast screening of females aged 50 to 70 in the last 36 months was 79% (CCG 72%, national 72%).

Bowel screening of patients aged 60 to 69 years in the last 30 months was 68% (CCG 63% and national 58%).

- Carried out immunisations in line with the national childhood vaccination programme. Uptake rates for children aged eight weeks to five years ranged from 36% to 100%; which were in line with the CCG averages of 31% to 98% (these included the Meningitis C vaccine which had lower rates of uptake across the CCG as a whole).
- Patients had access to appropriate health assessments and checks. These included NHS health checks for people aged 40 to 75. Where abnormalities or risk factors were identified, appropriate follow-ups were undertaken. The practice had undertaken 189 of these checks in the preceding 12 months.
- Pre-diabetes checks and screening for chronic obstructive pulmonary disease were undertaken with those patients who were deemed most at risk of developing those conditions.
- Provided advice and support with weight management.
- Undertook brief intervention work regarding smoking cessation and also referred to other avenues of support.
- Provided sexual health advice and contraception services, such as coil fittings and implants.
- Had access to other services, such as a health trainer who could provide additional support for patients with lifestyle advice.
- Promoted flu vaccinations and at 77% the uptake rate for influenza immunisation in the over 65s was higher than the CCG target of 75%.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that:

- Members of staff were courteous and helpful to patients and treated them with dignity and respect.
- There was a private room should patients in the reception area want to discuss sensitive issues or appeared distressed.
- Curtains were provided in consulting and treatment rooms to maintain the patient's dignity during examinations, investigations and treatment.
- Doors to consulting and treatment rooms were closed during patient consultations and that we could not hear any conversations that may have been taking place.
- Chaperones were available for those patients who requested one and it was recorded in the patient's record.

Data from the national GP patient survey showed respondents rated the practice higher than the CCG and national averages for many questions regarding how they were treated. For example:

- 97% of respondents said the last GP they saw or spoke to was good at listening to them (CCG 91%, national 89%)
- 91% of respondents said the last GP they saw or spoke to was good at giving them enough time (CCG 89%, national 87%)
- 94% of respondents said the last GP they spoke to was good at treating them with care and concern (CCG 88%, national 85%)
- 93% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG 91%, national 91%)
- 95% of respondents said the last nurse they saw or spoke to was good at giving them enough time (CCG 92%, national 92%)
- 93% of respondents said the last nurse they spoke to was good at treating them with care and concern (CCG 92%, national 91%)

All of the 40 comment cards we received were positive about the care they had received; many described the practice as being 'excellent'. They stated they felt listened to and cited staff as being caring, helpful, respectful and professional.

Patients we spoke with were all very positive about the staff and the practice. They gave us several examples to demonstrate how they had been cared for and treated. Patients said they didn't feel rushed, they felt listened to and that staff were friendly and caring.

Care planning and involvement in decisions about care and treatment

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

- The choose and book service was used with all patients as appropriate.
- Interpretation and translation services were available for patients who did not have English as a first language.
- There were information leaflets and posters displayed in the reception area available for patients.

Data from the national GP patient survey showed respondents rated the practice in line with other local and national practices, for some of the questions. For example:

- 89% of respondents said the last GP they saw was good at involving them in decisions about their care (CCG 85%, national 82%)
- 89% of respondents said the last GP they saw was good at explaining tests and treatments (CCG 89%, national 86%)
- 84% of respondents said the last nurse they saw was good at involving them in decisions about their care (CCG 86%, national 85%)
- 92% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG 91%, national 90%)

Patients' comments we received on the day aligned with those responses.

Patient and carer support to cope emotionally with care and treatment

The practice maintained a carers' register and the patient electronic record system alerted clinicians if a patient was a carer. At the time of our inspection the practice had identified 123 carers, which equated to just over 1% of the practice population. All carers were offered a health check and influenza vaccination. A member of staff acted in the capacity of carers' champion. Additional support was provided either by the practice or by signposting to other services as needed.

Good

Are services caring?

The practice worked jointly with palliative care and district nursing teams to ensure patients who required palliative care, and their families, were supported as needed. At the time of our inspection there were 14 patients on the palliative care register. We were informed that if a patient had experienced a recent bereavement, they would be contacted and support offered as appropriate.

We saw there were notices and leaflets in the patient waiting area, informing patients how to access a number of support groups and organisations. There was also information available on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with NHS England and Greater Huddersfield CCG to identify and secure provision of any enhanced services or funding for improvements. Services were provided to meet the needs of their patient population, which included:

- Extended hours appointments during weekdays.
- Home visits for patients who could not physically access the practice and were in need of medical attention.
- Urgent access appointments for children and patients who were in need.
- Longer appointments as needed.
- Open access clinics three mornings a week.
- Online services such as booking of appointments and re-ordering of prescriptions.
- Travel vaccinations which were available on the NHS and privately.
- Interpretation and translation services.
- Doppler ultrasound to measure blood flow, particularly used in patients who had a vascular ulcer.
- Access to electrocardiogram (ECG); which is a test that can be used to check the heart's rhythm and electrical activity.
- In-house hearing tests undertaken by a GP with a ear nose and throat (ENT) specialism.

The GPs liaised with the nursing home managers and had identified key members of staff who they could speak, to support patients receiving timely and appropriate medical care and treatment.

Access to the service

The practice was open Monday to Friday 7.30am to 6.30pm (the practice closed at 6pm on Friday). There was a responsive appointment system where appointments could be pre-booked six weeks in advance or made on the day. We saw the next available appointment was for the day of our inspection and the next pre-bookable appointment was in three days time. When the practice was closed out-of-hours services were provided by Local Care Direct, which could be accessed via the surgery telephone number or by calling the NHS 111 service.

The practice could evidence being responsive to demands on the appointment system. They booked locums when there were anticipated pressures in the appointment system. They were currently auditing demand and capacity and liaising with a local practice that had been successful in reviewing their own appointment system to the satisfaction of their patients. The practice had initially commenced the open access clinic one morning a week in response to patient demand. This had subsequently been increased to three mornings per week.

Data from the national GP patient survey showed satisfaction rates were variable compared to the CCG and national averages. For example:

- 72% of respondents were fairly or very satisfied with the practice opening hours (CCG 76%, national 78%)
- 43% of respondents said they could get through easily to the surgery by phone (CCG 75%, national 73%)
- 93% of respondents said the last appointment they got was convenient (CCG 93%, national 92%)

We discussed the lower than average satisfaction responses in relation to access by telephone. Up until August 2016 there had been a telephone system in place with a premium rate number and also a queuing system. Patients had reported dissatisfaction with the system. As a result the practice had negotiated a change in their telephone contract. Consequently, the telephone number was no longer premium rate and additional lines had been added. There had been a reported increase in satisfaction, however, the practice were still in the process of evaluating the changes.

Listening and learning from concerns and complaints

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

- The 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.
- The practice kept a record of all written complaints.
- All complaints and concerns were discussed at the practice meeting.
- There was information available in the practice, in the patient information leaflet and on the practice website, to help patients understand the complaints system.

There had been 10 complaints received in the last 12 months. We found they had been satisfactorily handled.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Lessons had been learned and action taken to improve quality of care. It was noted that five of these related to those patients being requested to register at a practice nearer to their homes, as they were out of the catchment areas for Lindley Group Practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision and robust strategy to deliver high quality, safe and effective care in response to the needs of patient within their community.

All staff knew and understood the practice vision and values. There was a strong patient-centred ethos among the practice staff and a desire to provide high quality care. This was reflected in their passion and enthusiasm when speaking to them about the practice, patients and delivery of care.

The GPs and manager could inform us what the strategy was for the practice over the coming years. They had recently undergone changes to their partnership and wanted to consolidate the team. They were driving forward issues regarding the premises with a view to enhancing their current service provision to patients.

Governance arrangements

There were good governance processes in place which supported the delivery of good quality care and safety to patients. We saw evidence of:

- A comprehensive understanding of practice performance. Practice meetings were held where practice performance, significant events and complaints were discussed.
- An organised approach to practice management.
- A system in place whereby after all policies had been updated, they were cascaded to staff who signed and dated a signatory sheet to say they had been seen. Policies were available to all staff via the computer or as a paper copy.
- Clinical audit being used to monitor quality and drive improvements.
- Arrangements for identifying, recording, managing and mitigating risks.
- A good understanding of staff roles and responsibilities. Staff had lead key areas, such as safeguarding, dealing with complaints and significant events, data and recall of patients, and infection prevention and control.
- Business continuity and comprehensive succession planning in place, for example the recruitment and development of staff.

Leadership and culture

There was clear leadership and staff told us the GPs and managers were very visible in the practice, approachable and could be easily accessed when needed. They described good working relationships between the GP partners and staff.

On the day of inspection the partners in the practice could demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. All staff told us they prioritised safe, high quality and compassionate care. We saw evidence of:

- Practice and clinical meetings being held.
- Formal minutes from a range of multidisciplinary meetings held with other health and social care professionals to discuss patient care and complex cases, such as palliative care.
- An inclusive team approach to providing services and care for patients.
- Systems in place to ensure compliance with the requirements of the duty of candour.

The culture of the practice was one of openness, honesty and supportive of patients and staff who worked there. Patients said they felt it was 'a family practice'. Staff said they felt very supported and proud of the service they provided.

Medical students informed us of the supportive nature of the practice and staff who worked there. They praised the good team work, said staff were friendly and described the GP trainer as being a 'brilliant and excellent teacher'.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through day to day engagement with them.
- Members of the patient reference group (PRG). The PRG had previously met face to face but numbers had dwindled. A decision had been made to have a 'virtual group'. The 10 members we spoke with informed us that they had good engagement with the practice and the practice manager regularly liaised with them to seek their views.

Are services well-led?

Good

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

- The NHS Friend and Family Test, complaints and compliments received. We saw evidence of a compliments book, which contained many positive and kind comments made by patients about the practice and staff.
- Staff through meetings, discussions and the appraisal process. Staff told us they would not hesitate to raise any concerns and felt involved and engaged within the practice to improve service delivery and outcomes for patients.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area:

- Working with other services to support positive patient experiences and care. For example, they were liaising with a local practice to look at how they could improve their appointment systems.
- Continue to improve discharge planning and communication with the local hospital.
- Maintain the high standards of teaching to trainee GPs and medical students.