Dr N A Nayyar & Partners - Riverside Medical Centre

Quality Report

Riverside Medical Centre
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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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr N A Nayyar and Partners at Riverside Medical Centre on 17 May 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients had a variety of appointment options which included sit and wait sessions, pre-bookable and urgent appointments and telephone consultation and advice.
- The practice provided 30 minute appointments for new mums and babies for the six week post-natal check. This additional time allowed the practice to offer improved levels of support and better meet identified needs.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice:

- The practice had a dedicated learning disability nurse who worked closely with learning disability patients, carers and other health and social care professionals to provide effective and accessible services. The practice had been involved in the development of templates for health checks in

Summary of findings

association with the local learning disability team, and had provided training and awareness raising amongst other practices of learning disability health care. Of 88 patients on the practice register of patients with a learning disability 94% had a health action plan in place which is reviewed annually. In addition we were provided with examples of how staff had gone out of their way to help patients with a learning disability resolve personal and social problems.

An area where the provider should make improvement was:

- The practice should review its records in relation to the immunity and vaccination status of its staff to ensure that these were up to date.

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.

- There was an effective system in place for reporting and recording significant events and lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- There was a nominated lead for safeguarding children and adults. Systems were in place to keep patients and staff safeguarded from abuse.
- There were processes in place for safe medicines management which included a programme of regular medication reviews.
- There were systems in place for checking that equipment was tested, calibrated and fit for purpose.
- Full immunity checks on staff had not been carried out or recorded in relation to conditions such as measles, mumps, rubella and chickenpox.

Are services effective?

Good

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.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits were through and demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice used a computer protocol for patients with autism to remind staff that they may need to adapt their

Summary of findings

communication methods to aid understanding. In addition they were in the process of identifying other patients with disabilities to ensure that their preferred communication requirements were met.

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 higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice demonstrated a patient centred approach. For example, it used novel and innovative ways to communicate effectively with patients with a learning disability.
- All patients assessed as being near the end of life were assigned a named GP to enable them to have improved continuity of care.
- The practice had a hearing loop available for those with a hearing impairment, and the waiting room, transit corridors and consultation rooms were large enough to facilitate wheelchair access.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- 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. For example, the practice had contributed to the development of and participated in a Wakefield Vanguard programme which sought to develop an approach to joined up health and social care services. The practice had 31 patients in homes covered by the programme and provided services which included advanced care planning and reviews, vaccinations and dementia screening. Data from the practice showed:
  - 67% of these patients had received a dementia review
  - 93% of these patients had an avoiding unplanned admissions care plan in place.
- The practice had a dedicated learning disability nurse who worked closely with learning disability patients, carers and

Summary of findings

other health and social care professionals to provide effective and accessible services. The practice has 88 patients on their learning disabilities register of which 94% had an annual health action plan in place. In addition we were provided with examples of how staff had gone out of their way to help patients with a learning disability resolve personal and social problems.

- Patients could access a specialist diabetic clinic held in the surgery which included insulin initiation services, and patients with more complex needs could access clinics delivered by the practice in conjunction with an external diabetes consultant and specialist diabetes nurse.
- There are innovative approaches to providing integrated patient-centred care. For example, the practice offered an avoiding unplanned admissions service which provided proactive care management and support for those patients who were at high risk of an unplanned hospital admission, this included patients with specific long term conditions.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- Patients can access appointments and services in a way and at a time that suits them. Patients had a range of appointment options which included sit and wait morning sessions, pre-bookable appointments, urgent appointments, telephone consultation and advice and home visits.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had appointed a GP with responsibility for complaint handling and investigation.
- Information about how to complain was available in the waiting area and on the practice website and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- Staff had contributed to the development of the practice mission statement and overall vision, and consequently this was clearly understood and embraced by all staff within the practice.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- 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 through effective communication methods that this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. Where deemed appropriate findings from audits were shared outside the practice with other health professionals.
- There was a strong focus on continuous learning and improvement at all levels, and the practice used new and innovative approaches to improve outcomes for patients in the area, these included the development of specialist services for learning disability patients and supporting the secondment of an advanced care practitioner to gain experience in the practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good 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 offered care planning and reviews for older patients with chronic diseases, these reviews were usually annual but could be as frequent as every three months if deemed appropriate to the needs of the patient. If appropriate multi-condition reviews were also available.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. All home visit requests were triaged to determine the necessity and urgency of visits.
- All patients over 75 years old had a named GP and had been informed of this by letter.
- The practice had contributed to a Wakefield Vanguard programme which sought to develop an approach to joined up health and social care services and to reduce emergency admissions. The practice had 31 patients in homes covered by the programme and provided services which included advanced care planning and reviews, vaccinations and dementia screening.

People with long term conditions

Good

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

- GPs and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. For example, the practice offered an avoiding unplanned admissions service which provided proactive care management and support for those patients who were at high risk of an unplanned hospital admission, this included specific long term conditions. In addition the practice held clinics for a number of conditions which included:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Coronary Heart Disease
  - Prostate cancer

Summary of findings

- Patients with long term conditions received information on disease management and were signposted to support groups and services. Patients also received regular reviews via the practice “Call and Recall” system. Wherever possible multi condition reviews were held to avoid repeated visits to the practice by patients. For example, in 2015/2016 140 patients with both cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD) had received a multi condition review.
- The practice offered specialist diabetic clinics which included insulin initiation and complex needs care planning.
- Longer appointments and home visits were available when needed.
- Clinicians within the practice had experience to deliver a wide range of specialist services which included those in relation to dermatology and musculoskeletal problems.

Families, children and young people

Good

The practice is rated as good 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 and the practice held regular monthly meetings with health visitors to discuss safeguarding issues.
- Immunisation rates were relatively high for all standard childhood immunisations and were between 99% and 100%.
- We were told 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 87%, which was above the CCG average of 83% and the national average of 82%. In addition the practice had an effective “Call and Recall” system in place to invite women aged 24-65 years for their screening appointment.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

- The practice provided 30 minute appointments for new mums and babies for the six week post-natal check. This additional time allowed the practice to offer improved levels of support and better meet identified needs.
- The practice had recently registered as a c-card distribution centre which gave improved access to contraceptives to young people.

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 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. For example, the practice offered a range of patient access options which included:
  - Walk in sessions
  - Pre-booked and on the day appointments
  - Telephone consultations
  - Online services (27% of patients had signed up for practice on-line services).
- The practice was proactive in offering a full range of health promotion and screening that reflects the needs for this age group such as NHS health checks.

People whose circumstances may make them vulnerable

Outstanding

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and those with poor mental health.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- 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 practice had a dedicated learning disability nurse who worked closely with learning disability patients, carers and other health and social care professionals to provide effective and accessible services. The practice had been involved in the development of templates for health checks in association with the local learning disability team, and had provided training and awareness raising amongst other practices of learning disability health care. The practice took a person centred approach in relation to consultations with the learning disability nurse using appropriate communication methods which included the use of pictures and easy access formats. Patients with a learning disability were given annual reviews; some of these were delivered in the patient's own home if they were unable to attend the surgery. Of 88 patients on the practice learning disability register 94% had a health action plan in place. In addition we were provided with examples of how staff had gone out of their way to help patients with a learning disability resolve personal and social problems.
- The practice worked closely with staff from learning disability residential settings and provided advice and guidance. They tailored appointments to meet the needs of the patient as some patients found it difficult to attend the surgery when there were large numbers of other patients around.
- The practice used a computer protocol for patients with autism to remind staff that they may need to adapt their communication methods to aid understanding. In addition they were in the process of identifying other patients with disabilities to ensure that their preferred communication requirements were met.
- The practice was registered under the Wakefield Safer Places Scheme. This voluntary scheme seeks to assist vulnerable people feel safer when travelling independently. Registered sites have agreed to offer support to the individual and would contact a named relative, carer or friend if the person was in distress. In

addition we were told that the practice took into account the needs of patients with dementia and held " Working Towards Dementia Friendly" status (this meant the practice had registered for the recognition process for dementia friendly accreditation and was working towards the named standards to become fully dementia friendly).

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).

- All patients with mental health issues were offered annual reviews, and a number received monthly reviews to meet their specific needs. This allowed the practice to monitor their symptoms and avoid deterioration in their mental health and wellbeing.
- The practice kept registers of those with poor mental health and dementia and used these to plan reviews. At the time of inspection the practice had 126 patients on its mental health register and 80 patients on its dementia register, these were slightly above the national prevalence figures.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out care planning for patients with dementia.
- Practice staff had a high level of knowledge of how to support those with poor mental health, this included being able to tell them about how to access various support groups and voluntary organisations.
- The lead GP had a special interest in mental health and was accredited to carry out Deprivation of Liberty Safeguards (DoLs) assessments.
- The lead GP also ensured that all staff had a good understanding of the Mental Capacity Act 2005 and DoLs. The GP also shared this knowledge through training and awareness raising with staff from other practices.

Summary of findings

- The practice had worked closely with other network colleagues and the Clinical Commissioning Group (CCG) to establish a local “Talking Shop”. When operational this would allow patients to quickly access a local, low level mental health service.
- 70% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months; this was below the CCG average of 89% and the national average of 88%.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and national averages. Of 285 survey forms that were distributed and 111 were returned which gave a response rate of 39%. This represented 1% of the practice's patient list.

- 51% of patients found it easy to get through to this practice by phone compared to the CCG average of 71% and the national average of 73%.
- 54% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 74% and the national average of 76%.
- 80% of patients described the overall experience of this GP practice as good compared to the CCG average of 85% and the national average of 85%.
- 76% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 81% and the national average of 79%.

The practice had reviewed these results and taken action to improve these which included:

- Upgrading the telephone system to include a call waiting message
- The addition of extra telephone lines
- The introduction of additional morning sit and wait sessions which had resulted in a reduction in the number of telephone calls as patients could simply turn up and wait for an appointment slot.

The practice felt that the survey satisfaction results in relation to appointments could be low as a result of the introduction of sit and wait sessions which meant that actual appointment availability was limited. However patients would always be seen if they attended one of these sit and wait sessions.

Recent data provided by the practice showed that in March 2016 the practice handled 7904 inbound calls, 99% of which were successful (1% were abandoned) with an average connection time of two seconds.

With regard to patient satisfaction the practice showed high Friends and Family Test approval with 91% recommending the practice to others. The practice also believed that the introduction of the morning sit and wait sessions would improve overall satisfaction in the future and reported that they had received positive feedback since its introduction and very few complaints.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards all of which which were positive about the standard of care received, although three of these responses also said that they were not in support of the practice introduction of sit and wait sessions.

We spoke with three patients during the inspection. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Dr N A Nayyar & Partners - Riverside Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Dr N A Nayyar & Partners - Riverside Medical Centre

The practice of Dr N A Nayyar and partners is located at the Riverside Medical Centre and provides services for around 10,800 patients in the Castleford area. The practice is part of the NHS Wakefield Clinical Commissioning Group.

The surgery is located in purpose built premises built in 1991. The building is accessible for those with a disability and on-site parking is available for patients.

The practice population age profile shows that it is similar to both the CCG and England averages for those over 65 years old (17% compared to the CCG average of 18% and England average of 17%). Average life expectancy for the practice population is 76 years for males and 81 years for females (CCG average is 77 years and 81 years respectively and the England average is 79 years and 83 years respectively). The practice population has significantly more patients with a long standing health condition at 65% compared to the CCG average of 58% and the national average of 54%. A higher than average population with a long standing health condition could mean increased demand for GP services. The practice serves some areas of higher than average deprivation. The practice population is predominantly White British.

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

- Childhood vaccination and immunisation
- Influenza and Pneumococcal immunisation
- Rotavirus and Shingles immunisation
- Support to reduce unplanned admissions.
- Minor surgery
- Learning disability support
- Patient participation

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

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

The practice has six GP partners (four male, two female), a salaried GP(female), a nurse practitioner, a practice nurse

manager, three practice nurses and three health care assistants (all female). The clinical team is supported by a practice manager, finance manager, office manager and a reception and administration team.

The practice is accredited as a training practice and supports GP registrars during their further training to become GPs.

The practice is open from 8am to 6.30pm Monday to Friday.

In addition through the local Federation patients can access Saturday morning appointments at Pontefract Hospital.

The practice offers a range of appointments which include:

- Pre-bookable appointments available to book up to four weeks in advance for a GP and up to eight weeks in advance for the nurse practitioner
- Same day sit and wait sessions on Mondays to Fridays between 8am and 10am, no appointment being required
- Book on the day appointments available in the afternoon
- Urgent appointments (the practice prioritises children under six years of age and anyone with a condition which requires urgent attention)
- Telephone consultations when patients can discuss their condition with a GP duty doctor from 8am to 6pm.

The practice also offers home visits to patients whose condition means that they are unable to attend the surgery.

Appointments can be made in person, on the telephone or online.

Out of hours care is provided by Local Care Direct Limited and is accessed via the practice telephone number or patients can contact NHS 111.

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 17 May 2016. During our visit we:

- Spoke with a range of staff, which included GP partners, nursing staff and the practice manager and members of the administration team.
- Spoke with patients who were all extremely positive about the practice and the care they received.
- Reviewed comment cards where patients and members of the public shared their views. All comments received were positive about the staff and the service they received.
- Observed in the reception area how patients were engaged with and treated by reception staff.
- Spoke with members of the patient participation group, who informed us how well the practice engaged with them.
- Looked at templates and information the practice used to deliver patient care and treatment plans.
- Spoke with NHS Wakefield Clinical Commissioning Group.

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:

Detailed findings

- 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 and recording significant events.

- 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.
- There was an open and transparent approach to safety. 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 with incidents being discussed at team meetings.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a practice patient had been prescribed the wrong dose of medication on discharge from hospital. The practice was made aware of this, and took immediate steps which included discussing with both the hospital and the patient's family and taking blood tests. The practice clarified that with other health professionals that the patient would not have suffered any long term harm from having received this dosage. Learning points included that clinicians should ensure that if prescribing an unfamiliar drug that they become fully acquainted with it to ensure they were using the recommended dose and to check with the consultant if any clarification was required.

Incident reports and patient safety alerts and updates were cascaded to staff via the practice computer systems and where necessary tasked for action by individuals, hard copies of these were also available. These were also discussed at weekly clinical meetings.

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 were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were lead members of staff and deputies for safeguarding. The GPs attended monthly safeguarding meetings. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Clinicians were trained in safeguarding to level three and non-clinical staff to level one.
- A notice in the waiting room advised patients that chaperones were available if required (a chaperone is a person who serves as a witness for both a patient and a medical professional as a safeguard for both parties during an intimate medical examination or procedure). The practice nurses and health care assistants who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We saw up to date cleaning schedules in place. A practice nurse was the infection prevention and control (IPC) lead. There was an IPC protocol in place and staff had received up to date training. We saw evidence that an IPC audit had taken place and action was taken to address any improvements identified as a result.
- 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 a default review every six

months (every three months for higher risk medicines). Vaccine storage refrigerators were operating at the correct temperatures and were being effectively monitored.

- The practice carried out regular medicines audits, with the support of the local CCG medicines optimisation team, 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 was qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They 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.
- We reviewed five 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. However, the practice had not fully reviewed the immunity and vaccination status of staff in relation to conditions such as measles, mumps, rubella and chickenpox.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- 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 carried out regular fire drills. 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 practice 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 bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty and when required the practice accessed the services of regular locums. A comprehensive locum pack had been produced by a registrar within the practice.

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. In addition the practice could use the telephone system to alert others in the event of an emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- 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. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

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. Updates and alerts were cascaded to staff and discussed at team meetings.
- The practice monitored that these guidelines were adhered to through clinical audits.

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 showed that the practice achieved 96% of the total number of points available. The practice exception reporting rate was 9% which was comparable with CCG and national averages (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). The practice had appointed a GP to lead on QOF and this was discussed at the weekly clinical meetings with progress being monitored and reviewed.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

- Performance for diabetes related indicators was comparable to the CCG and national averages. For example 79% of patients with diabetes had an HbA1C result which was within normal parameters, compared to 76% locally and 78% nationally. (HbA1c is a blood test which can help to measure diabetes management.) Additionally 90% of patients on the diabetes register had a record of a foot examination and classification in the preceding 12 months compared to a CCG average of 89% and a national average of 88%.
- Performance in relation to hypertension was comparable to the CCG and national averages. For example, 83% of patients with hypertension had a blood pressure reading which was within normal parameters compared to 85% locally and 84% nationally.

We saw that the practice used clinical audits, monitoring processes and other checks as a means of improving its service.

- We reviewed two full cycle clinical audits in relation selective serotonin re-uptake inhibitors (SSRI) dose reducing regimes and on the use of Domperidone which had been completed in the last two years, where improvements made were implemented and monitored.
- Findings from audits were used by the practice to improve services. For example, the practice had devised a drug dosage reducing regime for SSRIs (a class of drugs that are typically used as antidepressants) and had worked with patients to support and empower them during the time they were moving off the drug. When audited the results endorsed the managed approach taken by the practice and this was further supported when a reaudit was carried out two years later. This approach and the audit had been presented to the CCG medicines optimisation team and shared with other practices locally.

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 could demonstrate how they ensured role-specific training and updating for relevant staff.
- The practice was a training practice and practice GPs were accredited trainers.
- The lead GP had extensive experience in the field of mental health and had shared this experience with practice staff and other health professionals.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of

Good

Are services effective?

(for example, treatment is effective)

competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice 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 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.

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 shared relevant information with other services in a timely way, for example when referring patients to other services.

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. Meetings took place with other health care professionals on a monthly basis to discuss palliative care and patients with complex needs, at these meetings care plans were routinely reviewed and updated. The practice shared details of palliative care patients with the out of hours provider to ensure that they held the appropriate information and were therefore better placed if called to a patient when the practice was closed.

The practice kept detailed registers of people with long term conditions and those receiving palliative care. These registers supported the delivery of services and in particular the care planning and review process.

Within the practice care plans were reviewed as a minimum every 12 months, with some patients having care plans reviewed every three months if their needs required this. If a patient was admitted to hospital the practice aimed to contact them within three days of discharge to discuss their ongoing needs.

The practice offered electonic-consultations with secondary care specialist consultants (an e-consultation is a mechanism that enables primary care providers such as GPs to obtain specialists' inputs into a patient's care treatment without requiring the patient to go to a face-to-face visit by using IT based communication links and data sharing). As well as a reduction in the need for patients to visit secondary care providers, it also meant that they received more timely advice and treatment than would be otherwise the case.

Consent to care and treatment

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

- The lead GP had a special interest in mental health and carried out Deprivation of Liberty Safeguards (DoLs) assessments for both the practice and for other practices on request.
- Under the lead GP the practice ensured that all staff had an excellent understanding of the Mental Capacity Act 2005 and the relevant consent and decision-making requirements of legislation and 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.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

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:

Good

Are services effective?

(for example, treatment is effective)

- who were in the last 12 months of their lives
- at risk of developing a long term condition
- who required healthy lifestyle advice, such as in relation to diet and weight management, smoking cessation and alcohol reduction
- who acted in the capacity of a carer and may have required additional support

The practice coded patients on its records such as patients who were on the autistic spectrum disorder; this enabled additional support to be provided as needed for both the patient and/or carer.

The practice's uptake for the cervical screening programme was 87%, which was above the CCG average of 83% and the national average of 82%.The practice had an effective "Call and Recall" system in place to invite women aged 24-65 years for their screening appointment.

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 abnormalities. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for vaccinations given were better than CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 99% to 100% (CCG averages ranged from 94% to 98%) and for five year olds ranged from 99% to 100% (CCG averages ranged 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.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff 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.
- High backed chairs with arm rests were provided in the waiting room, these were more suited to the needs of elderly patients and those with mobility issues.

We were told the practice took a person centred approach in relation to the care and treatment it gave to patients. For example, during consultations with patients with a learning disability the specialist nurse used innovative communication methods which included the use of pictures and other easy access formats. We were told by the practice of examples when staff had gone above and beyond their designated role to support individual patients.

All patients assessed as being near the end of life were assigned a named GP to enable them to have improved continuity of care and support to both patients and carers through this time.

The practice was registered under the Wakefield Safer Places Scheme. This voluntary scheme seeks to assist vulnerable people feel safer when travelling independently. Registered sites have agreed to offer support to the individual and would contact a named relative, carer or friend if the person was in distress. In addition we were told that the practice took into account the needs of patients with dementia and held " Working Towards Dementia Friendly" status (this meant the practice had registered for the recognition process for dementia friendly accreditation and was working towards the named standards to become fully dementia friendly).

Of the 23 patient Care Quality Commission comment cards we received all were positive about the clinical services delivered by the practice, although three of these responses also said that they were not in support of the practice introduction of sit and wait sessions. Patients said they felt the practice staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). 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 generally above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 80% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% 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 and felt that staff communicated with them openly. They also told us they felt listened to and supported by staff and had sufficient

Good

Are services caring?

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 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:

- 85% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

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

- Staff told us that were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.
- The practice had a hearing loop available for those with a hearing impairment and the waiting room, transit corridors and consultation rooms were large enough to accommodate wheelchair users.

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, this included carers and bereavement support information. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 177 patients as carers (around 2% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had experienced a bereavement that they would contact them by telephone and offer support which included counselling and signposting to other services and voluntary groups.

Good

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) and had worked to develop and deliver a range of services to meet this identified need. Services and activities included:

- The practice had a dedicated learning disability nurse who worked closely with learning disability patients, carers and other health and social care professionals to provide effective and accessible services. The practice had been involved in the development of templates for health checks in association with the local learning disability team, and had provided training and awareness raising amongst other practices of learning disability health care. The practice took a person centred approach in relation to consultations with the learning disability nurse using appropriate communication methods which included the use of pictures and easy access formats. Patients with a learning disability were given annual reviews; some of these were delivered in the patient's own home if they were unable to attend the surgery. At the time of inspection the practice had 88 patients on their learning disability register and of these patients 94% had a health action plan in place.
- The practice worked closely with staff from learning disability residential settings and provided advice and guidance. They tailored appointments to meet the needs of the patient as some patients found it difficult to attend the surgery when there were large numbers of other patients around.
- The practice had contributed to and participated in a Wakefield Vanguard programme which sought to develop an approach to joined up health and social care services and to reduce emergency admissions.The practice had 31 patients in homes covered by the programme and provided services which included advanced care planning and reviews, vaccinations and dementia screening. Data from the practice showed that 67% of patients had received a dementia review and 93% had an avoiding unplanned admissions care plan in place.
- The practice offered an avoiding unplanned admissions service which provided proactive care management and support for those patients who were at high risk of an unplanned hospital admission, this included specific long term conditions. If a patient had attended hospital as an emergency the practice contacted the patient within three days of discharge to review their needs. Clinicians were made aware of an admission and the need to contact the patient via a coded "pop up".
- The needs of diabetic patients were met via the provision of a specialist diabetic clinic. The practice had reviewed 40 patients under the diabetes programme and offered in-house insulin and GLP initiation (GLP is a class of injected drugs for the treatment of type 2 diabetes) and advanced care planning. Treatment in the surgery meant that patients did not need to attend secondary care settings to receive treatment. In 2015/2016:
  - Seven patients were initiated onto insulin by the practice
  - Seven patients were initiated onto a GLP
  - Two patients were initiated onto insulin following GLP failure.

The practice had carried out a patient survey in March 2916 into this service and results showed satisfaction rates were positive. For example, 88% felt involved in decision making and 94% felt that they had received advice to help them understand their condition.

For diabetic patients with more complex needs the practice held joint clinics with an external diabetes consultant and specialist diabetes nurse.

- There were longer appointments available for certain patients such as those with a learning disability and frail older people with complex needs. In addition the practice tailored appointments to meet the needs of the patient as some learning disability patients found it difficult to attend the surgery when there were large numbers of other patients around.
- The practice actively monitored the availability of appointments and used this data to meet the needs of the local population. For example, the practice had recently expanded the morning sit and wait sessions from three days a week to five as this was felt to meet local patient demand. Patient feedback verbally, via Friends and Family Test data, and a PPG survey showed that patients in general liked the sit and wait sessions.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Clinicians also reported that the use of this process was less stressful and allowed them to give the patient the necessary amount of attention and care. The practice was aware that this system did not suit all patients and reported that a small number do not like this but they could access appointments in other ways.

- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments and home visits were available for those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.

Access to the service

The practice was open between 8am to 6.30pm Monday to Friday. In addition through the local Federation patients could access Saturday morning appointments at Pontefract Hospital.

The practice offered a range of appointments which included:

- Pre-bookable appointments available to book up to four weeks in advance for a GP and up to eight weeks in advance for the nurse practitioner
- Same day sit and wait sessions on Mondays to Fridays between 8am and 10am, no appointment being required
- Book on the day appointments available in the afternoon
- Urgent appointments (the practiceprioritises children under six years of age and anyone with a condition which requires urgent attention)
- Telephone consultations when patients could discuss their condition with a GP duty doctor from 8am to 6pm.

The practice also offered home visits to patients whose condition meant that they are unable to attend the surgery. Appointments could be made in person, on the telephone or online. Other online services included repeat prescription ordering. At the time of inspection 27% of patients in the practice had signed up to receive online services.

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

- 80% of patients were satisfied with the practice's opening hours compared to the CCG average of 81% and the national average of 78%.
- 51% of patients said they could get through easily to the practice by phone compared to the CCG average of 71% and the national average of 73%.

The practice had reviewed these results and taken action to improve these which included:

- Upgrading the telephone system to include a call waiting message
- The addition of extra telephone lines
- The introduction of additional morning sit and wait sessions which had resulted in a reduction in the number of telephone calls as patients could simply turn up and wait for an appointment slot.

People told us on the day of the inspection that they were able to see GPs and nurses when they needed them.

The practice had a triage system in place to assess:

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

The practice carried this out by discussing with the patient their symptoms and needs and using this to make an informed decision based on 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 would be 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice had appointed a GP with responsibility for complaint handling and investigation. On a daily basis complaints were dealt with by the practice manager. Complaints were routinely discussed at weekly clinical meetings.
- We saw that information was available in the surgery and on the practice website to help patients understand the complaints system.

We looked at 13 complaints received in the last 12 months and found that these had been handled appropriately and in a timely and open manner. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a patient had complained that due to being given insufficient information as to why some follow up tests were required they had become anxious and worried. The practice had assessed this and put in place new instructions which ensured that staff inform patients fully as to why follow up tests are required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- Staff had contributed to the development of the practice mission statement and overall vision, and consequently this was clearly understood and embraced by all staff within the practice.
- The practice had a strategy and supporting business development plan which reflected the vision and values and were regularly monitored.
- The practice management team had an good understanding of the challenges faced by the practice which included:
  - Recruitment and retention of staff
  - Financial constraints
  - The increasing expectations being made on general practice
  - Local housing developments which would increase demand.

The practice was proactively planning responses to these challenges through staff development, joint working with others including the local Federation, and through the adoption of improved working practices such as e-consultations.

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.
- Practice specific policies were implemented and were available to all staff.
- 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. Where deemed appropriate findings from audits were shared outside the practice with other health professionals.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they 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. Staff told us the partners were very approachable and always took the time to listen to all members of staff. The lead GP acted as chair of the local GP Network.

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

Are services well-led?

Good

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

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.

- Feedback from registrars within the practice was positive.
- The practice main meeting room was a valuable resource and the noticeboards within it had been used to display important information to staff such as QOF performance data, details of complaints and significant events, key meeting dates and information of current interest such as work with regard to female genital mutilation.

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.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had asked the practice to alter the layout of the chairs in the main waiting area to face away from the reception desk and to move the self-check in screen away from the reception desk due to concerns with regard to confidentiality. In response the practice had made the necessary alterations. The practice also supported the PPG in the production of a seasonal PPG newsletter which gave patients additional information with regard to the PPG and the role patients could play in further improving services.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us on the day that they felt 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 part of local pilot schemes to improve outcomes for patients in the area. Examples of the kind of work the practice had taken the lead on included:

- The practice had contributed to and participated in a Wakefield Vanguard programme which sought to develop an approach to joined up health and social care services and to reduce emergency admissions.
- The senior partner took had a lead role both within the practice and the locality regarding mental health.He provided training, support and advice to other practitioners and has meant that patients have received better support from GP across the locality.
- The practice had developed specialised services to meet the needs of its population in areas such as learning disability, diabetes and mental health.
- Supported the secondment of a paramedic into the practice to gain experience as an advanced care practitioner (ACP). The secondment offered the ACP the opportunity to retain their current emergency paramedic skills whilst developing new primary care skills in a supported environment. The practice felt that the development of the ACP role would help tackle the recruitment challenge within general practice and enable the practice to provide improved services to patients.
- The practice had worked closely with other network colleagues and the Clinical Commissioning Group (CCG) to establish a local "Talking Shop". When operational this would allow patients to quickly access a local, low level mental health service.