The North Leeds Medical 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

Overall summary

We carried out an announced comprehensive inspection at The North Leeds Medical Practice on 8 July 2015. The practice also has a branch surgery located at Milan Street, Leeds, this was visited as

part of this inspection. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. It was also good for providing services for all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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.
- Patients said they found it very easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

We saw areas of innovative and outstanding practice:

- The practice used data of appointment patterns over the previous ten years in order to predict how many appointments were needed each day. As a result they were able to offer appointments in accordance with varying demand on the day.
- Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas which informed patents

Summary of findings

this service was available. The practice produced leaflets in Urdu, Hungarian, Czech, Slovak, Romanian, Hungarian, Portuguese as well as English. Items covered included how to make an appointment, telephone consultations, if there is a need to see a GP urgently and if an interpreter was required.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data 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. Information for patients about the services available was easy to understand and accessible. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues 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. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. The premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

Summary of findings

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. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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.

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 experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The most recent information from Public Health England (2015) for the North Leeds Medical Practice, which includes the Milan Street surgery, showed 80% of patients would recommend this practice to others. This was above the national average. Eighty five per cent were happy with the opening hours which was higher than the national and local Clinical Commissioning Group (CCG) averages. We received 19 completed CQC patient comment cards and spoke with five patients on the day of our visit. All the patients' comment cards were positive about the care provided by the GPs, the nurses and reception staff with many comments conveying the excellent service they received by the practice overall. They all felt the doctors and nurses were competent and knowledgeable about their health needs. Although one comment card did describe how a patient had to rebook an appointment after they turned up late. The practice has an active Patient Participation group (PPG) and we spoke with a member of this group. Patients we spoke with said the practice was always clean and tidy.

The North Leeds Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP and a practice manager, who were all specialist advisors.

Background to The North Leeds Medical Practice

The North Leeds Medical Practice is located at Harrogate Road and Milan Street, Leeds, West Yorkshire. The practice has off road parking facilities and disabled access. There is a disabled parking bay at the Harrogate Road site. The Harrogate Road site is currently operating out of portacabins due to the building having been demolished and a new building being erected.

The practice is registered with the CQC to provide primary care services. The practice provides primary care services for 15,700 patients under a Personal Medical Services (PMS) contract with NHS England in the North Leeds Clinical Commissioning Group (CCG) area. The PMS contract is a contract between a general practices and NHS England for delivering primary care services to local communities.

There are six male GPs, four female GPs, a nurse practitioner, four practice nurses, a treatment room nurse, two phlebotomists and two health care assistants. They are supported by a business manager consultant, two reception managers who lead a team of 21 administration and reception staff which cover both sites.

The practice is open at Harrogate Road from 8.00am to 6.00pm Monday to Friday. Extended hours are available, with a late night surgery twice a week on Monday and Thursday evenings from 6.00pm to 8.00pm. The practice is open at Milan Street from 8.00am to 6.00pm Monday to Friday. Extended hours are available, with a late night surgery twice a week on Tuesday and Wednesday evenings from 6.00pm to 8.00pm.

The practice treats patients of all ages and provides a range of medical services. Out of hours care is provided by Local Care Direct.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. This 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.

Please note 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.

Detailed findings

How we carried out this inspection

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 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)

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 8 July 2015. During our visit we spoke with a range of staff including the business manager consultant, two reception managers, four GPs, two practice nurses and two members of the reception staff. We also spoke with five patients on the day. We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 19 CQC patient comment cards where patients had shared their views and experiences of the service. We also reviewed records relating to the management of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for how they reported, recorded and monitored significant events, incidents and accidents. We reviewed records of 41 significant events divided into clinical and administration that had occurred during the last year. We saw this system was followed appropriately, there were no obvious themes. Significant events were a standing item on the practice meeting agenda and a meeting was held monthly to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. For example, staff made an appointment which required an interpreter but did not allow extra time to be allocated. This was discussed and resulted in notes being made on patient records to show when the patient required an interpreter and to allow an extended appointment.

Staff, which included receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to one of the partners. We saw the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. This was evident when, for example, a practice in another area had been updating the wrong patient file. As a result of the intervention by The North Leeds Medical Practice a patient was given a new NHS number and the patient file updated with the correct patient information. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again..

National patient safety alerts were disseminated by one of the reception managers to the practice clinicians. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were emailed to the relevant staff and then discussed at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. There was active engagement in local safeguarding procedures and effective working with other relevant organisations.

There was a chaperone policy, which was visible in the reception area and in consulting rooms. (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 the receptionists had been trained to be chaperones; they would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when they acted as chaperones, this included where to stand to be able to observe the examination. All staff who undertook chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy which ensured medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance, as these were tracked through the practice and kept securely at all times.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence nurses had received appropriate training.

We saw a positive culture in the practice on how they reported and learned from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

The practice had established a service for patients to pick up their prescriptions and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients who collected medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had recently taken on a business consultant manager who had identified gaps within the cleaning process. A risk assessment had been carried out and a cleaning agency who specialised in the cleaning of GP surgeries had visited both premises and also made recommendations. The business consultant manager also updated the equipment used to clean the premises in line with Department of Health and Health Protection Agency guidance.

An infection prevention and control (IPC) policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection prevention and control who provided advice on the practice IPC policy. All staff received training about infection control specific to their role and received updates.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We were told the practice carried out regular checks in line with this policy to reduce the risk of infection to staff and patients. The

practice had also undertaken a risk assessment for legionella for the temporary porta cabins in line with the contractual agreement with the builders of the new premises.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers which indicated the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy which set out the standards it followed when they recruited clinical and non-clinical staff. Records we looked at contained evidence of recruitment checks which 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 (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for how they planned and monitored the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. There was also an arrangement in place for members of staff, which included nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The reception managers showed us records to demonstrate how actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes both planned and unplanned. We saw an example of this when the telephones had not been turned off the previous evening and the mitigating actions which had been put in place. The implemented learning was then shared with all staff who were responsible for locking up.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. Emergency equipment was available which included access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly. We checked the pads for the automated external defibrillator were within their expiry date. The notes of the practice's significant event meetings showed staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Good

Are services safe?

The practice had carried out a fire risk assessment in July 2015 due to moving into the porta cabins at Harrogate Road surgery, these included actions required to maintain fire safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the reception managers, business consultant manager, GPs and nurses how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about how they asked for and provided colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met to assist in reducing the need for them to go into hospital. We saw after patients were discharged from hospital they were followed up which ensured all their needs continued to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in how they monitored and improved outcomes for patients. These roles included data input, scheduled clinical reviews, and how they managed child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last year. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the asthma audit showed there had been a re-audit 12 months later which identified there had been an improvement in the prescribing of peak flow meters (calibrated instrument used to measure lung capacity in monitoring breathing disorders.)

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures). For example, we saw an audit on antibiotic prescribing. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 95% of the total QOF target in 2014, which was just above the national average of 94%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average. For example 95% of patients on the diabetes register had received their influenza immunisation in the period from 1 September to 31 March. The national average was 93%.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- Performance for mental health related and hypertension QOF indicators were similar to the national average.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients who received repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicine alerts when the GP prescribed medicines. We saw evidence after they received an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example older people and those patients with long term conditions. Structured annual reviews were also undertaken for people with long term conditions.

The practice participated in local benchmarking run by the Leeds North Clinical Commissioning Group (LNCCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes which had been evaluated well by LNCCG in avoidable admissions, were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in how they provided training for relevant courses.

Practice nurses and health care assistants had job descriptions which outlined their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties. For example, on administration of vaccines. Those with extended roles, such as the nurse practitioner who coordinated the project on avoidable admissions, were able to describe the role and the specific training they had received.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital which included discharge summaries, out-of-hours GP services and the 111

Good

Are services effective?

(for example, treatment is effective)

service both electronically and by post. The practice outlined the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively low at 12% compared to the national average of 14%. This is significant particularly in view of the size of the practice and patient list and the characteristics of the patient list. We saw the policy for actioning hospital communications was working well in this respect. The practice undertook an audit of follow-ups to ensure inappropriate follow-ups were documented and none were missed.

The practice held regular multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses. Decisions about care planning were documented in a shared care record and. staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. One of the partners was testing the use of an encrypted laptop which carried the full medical records of the patients to be visited which was useful during home visits of older people.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence audits had been carried out to assess the completeness of these records and the action taken to address any shortcomings identified.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For example, a specific scenario was brought to the attention of GPs by a patient who did not want a do not attempt resuscitation order in place if such an event should happen. The practice supported patients to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it.) When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and well-being.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice's performance for the cervical screening programme was 74%, which was below the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 80%, and at risk groups 57%. These were both above the national averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey for 2015.

The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed its satisfaction scores at the practice on consultations with doctors and nurses. For example:

- 89% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 88% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive but there were no common themes to this. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation, treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when they discussed patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 86% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the reception manager. The reception managers and the business consultant manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 89% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 82%.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas which informed patents this service was available. Plus members of staff had taken it upon themselves to produce leaflets in Urdu, Hungarian,

Good

Are services caring?

Czech, Slovak, Romanian, Hungarian, Portuguese as well as English. Items covered included how to make an appointment, telephone consultations, if there is a need to see a GP urgently and if an interpreter was required.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The patients we spoke with on the day of our inspection and the CQC patient comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement a sympathy card was sent from the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). An example of this was a patient-led diabetic group which had been set up in November 2014 to assist patients manage their condition.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities.

There was a waiting area with limited space in the porta cabins space wheelchairs and prams. At Milan Street while there were two floors patients with mobility issues were seen on the ground floor consulting rooms.

Staff told us they would see any patients who were of "no fixed abode" if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The surgery was open from 08:00 to 18:30 Monday to Friday. The practice is open at Harrogate Road from 8.00am to 6.00pm Monday to Friday. Extended hours are available, with a late night surgery twice a week on Monday and Thursday evenings from 6.00pm to 8.00pm. The practice is open at Milan Street from 8.00am to 6.00pm Monday to Friday. Extended hours are available, with a late night surgery twice a week on Tuesday and Wednesday evenings from 6.00pm to 8.00pm.

The practice treats patients of all ages and provides a range of medical services. Out of hours care is provided by Local Care Direct.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to a local care home, by a named GP and to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 75% were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 74%.
- 79% described their experience of making an appointment as good compared to the CCG average of 75% and national average of 74%.
- 77% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%.
- 85% said they could get through easily to the surgery by phone compared to the CCG average of 80% and national average of 74%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed they could see a doctor on the same day if they felt their need was urgent, although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking in advance. Comments received from patients also showed those in urgent need of treatment had been able to make appointments on the same day of contacting the practice. This was as a result of the practice checking their records for the last 10 years and using this data in order to predict appointments for each day of the year. As a result of this it they even had days when there were spare appointments available. They had sufficient clinicians who were able to see the patients due to the use of this data.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system. This was in a leaflet form available from the reception areas, the practice leaflet and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One of the patients we spoke with had made a complaint about the practice. We discussed this with the business consultant manager as the complaint was ongoing.

We looked at 17 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and there was openness and transparency in how the practice dealt with the complaints.

The practice reviewed complaints to detect themes or trends. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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. We found details of the vision and practice values were part of the practice's strategy and business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice The practice vision and values included, providing high quality and effective primary medical services for patients which included consultations, medication and advice. They also sought to provide good health and prevention for their patients.

We spoke with nine members of staff who knew and understood the vision and values and what their responsibilities were in relation to these. Some of the staff had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of these policies and procedures and staff we spoke with confirmed they had read the policies. Policies and procedures we looked at had been reviewed.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection prevention and control and the senior partner was the lead for safeguarding. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and business consultant manager took an active leadership role for overseeing the systems in place to monitor the quality of the service were consistently being used and were effective. This included use of the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the antibiotic prescribing audit. Evidence from other sources, which included incidents and complaints, was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and we saw evidence action had been taken, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example the recent fire risk assessment of the porta cabins at Harrogate Road. The practice monitored risks on a regular basis to identify any areas which needed addressing. The practice held monthly staff meetings where governance issues were discussed.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw team meetings were held every month. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted team away days were held. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. (A PPG is a group of patients

Are services well-led?

Good

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

registered with a practice who work with the practice to improve services and the quality of care). It had an active PPG which included representatives from various population groups. The PPG had carried out surveys and met every three months. The business consultant manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. Minutes from the previous PPG meetings were available on the practice website. We spoke with a member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

We also saw evidence the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraged patients to be involved in how they shaped the service delivered at the practice.

The practice had also gathered feedback from staff through staff away days and generally 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 they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Although a member of staff we spoke with felt they were challenged in their current role and felt they could have been included in more practice meetings. We looked at four staff files and saw regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. This included clinical and administration events and incidents, for example issues over vaccinations and comments made on the NHS choices website.