

Robin Lane Health and Wellbeing Centre

Quality Report

Robin Lane

Pudsey

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Date of inspection visit: 29 June 2016

Date of publication: 13/12/2016

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

Ratings

Overall rating for this service

Outstanding



Are services safe?

Good



Are services effective?

Outstanding



Are services caring?

Good



Are services responsive to people's needs?

Outstanding



Are services well-led?

Outstanding



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	9
What people who use the service say	14
Outstanding practice	14

Detailed findings from this inspection

Our inspection team	16
Background to Robin Lane Health and Wellbeing Centre	16
Why we carried out this inspection	16
How we carried out this inspection	16
Detailed findings	19

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Robin Lane Health and Wellbeing Centre on 29 June 2016. Overall the practice is rated as outstanding.

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

- There was an open and transparent approach to safety. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning were maximised.
- Risks to patients were assessed and well managed. There was a comprehensive risk register in place (quality assurance document) which identified risks, actions to mitigate the risk and what review arrangements were in place.
- Infection prevention and control was a regular agenda item at the practice meetings.
- All patients had access to extensive facilities and support groups, which were available at the Health and Wellbeing Centre.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the provision of ophthalmology services and the elderly care pathway.
- Patients' needs were assessed and care was delivered following local and national care pathways and National Institute for Health and Care Excellence (NICE) guidance. Staff had 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.
- Patients had good access to appointments and telephone consultations, which included appointments during extended hours; early morning, evenings and on Saturdays.
- The practice also conducted an annual outreach programme. This was to seek out patients across Leeds who were not currently registered with a GP practice and ensure they received appropriate care, treatment and support.
- There were strong and visible clinical and managerial leadership and governance arrangements in place.

Summary of findings

- The practice proactively engaged with their patient population and stakeholders regarding the delivery and development of services.

We saw several areas of outstanding practice:

- The practice had developed a Care of the Elderly pathway, aimed at those patients who were housebound, at a high risk of hospitalisation or residing in a care or nursing home. This pathway had been shared and implemented across other Leeds practices. They had developed an 'elderly care team' and as a result the practice could evidence a 23% reduction in unplanned hospital admissions and an 80% reduction in urgent home visits for this population group.
- There was a walk-in service for all routine or urgent health matters, which ran from 8am to 4pm Monday to Saturday each week. There was evidence to support that there had been an overall reduction in A&E attendance by 10% and an overall reduced demand for appointments in the usual bookable clinics by 26%.
- The practice had developed the health and wellbeing centre where patients and members of the local community could attend. Facilities included an onsite café, arts events, a variety of support groups and over 60 free volunteer run activities.
- The practice promoted sharing and learning and linked with a number of organisations in this country and around the world to use best practice to develop their services. This was evidenced in the number of organisations who had approached the practice to share their innovative approach to primary care, such as the smartphone app, elderly care pathway and the formation of the health and wellbeing centre.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- Risks to patients were assessed and well managed.
- There were effective systems in place for reporting and recording significant events and near misses. Staff understood their responsibilities in respect of these. There was evidence of investigation, actions taken to improve safety in the practice and shared learning with staff. The practice undertook annual thematic reviews of all recorded incidents.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.
- The practice had a bespoke overarching risk and governance assurance framework in place. It provided an instant snapshot showing how the practice was performing and identified areas of weakness. It was updated on a daily basis and reviewed by the partners.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- There were systems in place for checking that equipment was tested, calibrated and fit for purpose.
- There was a nominated lead for infection prevention and control (IPC) and regular IPC audits were undertaken in line with guidance. Infection prevention and control was a regular agenda item for discussion at the practice meetings.
- The practice employed a clinical pharmacist to support safe and effective prescribing and medicines management.
- 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.

Are services effective?

The practice is rated as outstanding for providing effective services.

Outstanding



- Staff had the skills, knowledge and experience to deliver effective care and treatment. They assessed the needs of patients and delivered care in line with local pathways and national guidance. There were effective systems in place to ensure all clinicians were up to date with National Institute for Health and Care Excellence (NICE) guidelines.

Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally in line with local and national averages. However, exception reporting was higher than local and national averages in some areas.
- Services were provided to support the needs of the practice population, such as screening and vaccination programmes, health promotion and preventative care.
- Patients and members of the Pudsey community had access to a wide range of group activities provided each month at the wellbeing centre. These activities included chair based exercise, Dementia Singing for the Brain and ukele groups.
- There was good evidence of working with other health and social care professionals to meet the range and complexity of patients' needs.
- End of life care was delivered in a compassionate and coordinated way.
- There was an appraisal process in place, which included training development plans, that took place on a quarterly basis for all clinical and non-clinical staff.
- We saw evidence of clinical audits which could demonstrate quality improvement.
- The practice participated in annual QIPP (Quality Improvement Productivity and Prevention) which provided analysis of appointments, referrals and DNA (did not attend) rates. This information was broken down to an individual clinician level and was used to improve clinical effectiveness.
- The practice had developed a Care of the Elderly pathway, aimed at those patients who were housebound, at a high risk of hospitalisation or residing in a care or nursing home. This pathway had been shared nationally and implemented across other Leeds practices. They had also employed a practice matron who specifically focussed on the care and support for this group of patients. As a result, the practice could evidence a 23% reduction in unplanned hospital admissions for this population group.
- Patients had access to a consultant-led ophthalmology service facilitated by Robin Lane Health and Wellbeing Centre. This supported a reduced need to attend secondary care services. Patients' feedback regarding this service was very positive.
- We saw evidence that reviews of interventions with patients who had mental health issues, showed an increase in those patients' health and wellbeing.

Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Data from the National GP Patient Survey showed variable results in comparison to the local CCG and national averages, when patients were asked about their care.
- Comments from patient showed they were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment.
- We observed that staff treated patients with kindness, dignity, respect and compassion.
- Clinical and administrative staff demonstrated a commitment to providing good care for their patients.
- There was a carers' register and all carers were referred to a local voluntary service for additional support and advice. The practice facilitated a carers' support group which was held on a monthly basis. Details were displayed in the practice and also on their website.
- There was a variety of information available for patients about the services, which was easy to understand and accessible.

Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

- The practice worked with Leeds West Clinical Commissioning Group (CCG) and other organisations to support delivery of services for the needs of their population. For example, the development of the ophthalmology service
- The practice had good facilities and was well equipped to treat patients and meet their needs. They had developed a health and wellbeing centre where patients and members of the local community could attend. Facilities included an onsite café, arts events, a variety of support groups and over 60 free volunteer run activities.
- The practice offered a sexual health clinic on Thursday afternoons. In addition there was a walk-in sexual health clinic available between 8am and 4pm on Saturdays.
- Patients had access to a dermatology review service run by a specialist dermatology nurse practitioner, which reduced the need for patients to attend a secondary care service.
- Patients had good access to appointments, which included extended hours on Monday to Saturday.
- There was a walk-in service for routine or urgent health matters, which ran from 8am to 4pm Monday to Saturday each week.

Outstanding



Summary of findings

There was evidence to support that there had been an overall reduction in A&E attendance by 10% and an overall reduced demand for appointments in the usual bookable clinics by 26%.

- All patients requiring urgent care were seen on the same day as requested. There were longer appointment and home visits for those patients who needed them.
- The practice undertook regular reviews of demand and capacity and had developed services, such as the walk-in service, to meet those demands and improve patient experiences. These had also contributed to a reduction in accident and emergency attendances and a decrease in the numbers of DNAs.
- There was an accessible complaints system. Evidence showed the practice responded quickly to issues raised and learning was shared with staff.
- The practice had developed a smartphone app that enabled patients to request appointments, order prescriptions, send secure messages to clinicians, record their own health issues or view health information videos. Evidence had shown the app was widely used and had been effective in reaching patients who may not ordinarily interact with GP services.

Are services well-led?

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

- 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 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 practice proactively engaged with their patient population and stakeholders regarding the delivery and development of services. This was demonstrated by the four year strategy document which identified their vision, mission and values and how they would be delivered. The strategy had been developed in collaboration with staff, patients and stakeholders, who were encouraged to continue to contribute towards future developments and delivery of the strategy.
- There was a high level of constructive engagement with staff, which was evidenced in their Staff Engagement Exercise which took place in January/February 2016.

Outstanding



Summary of findings

- The practice promoted sharing and learning and linked with a number of organisations in this country and around the world to use best practice to develop their services. This was evidenced in the number of organisations who had approached the practice to share their innovative approach to primary care. For example, development of the smartphone app, the elderly care pathway and the transformation of Robin Lane Medical Centre into a health and wellbeing centre.
- In 2013 the practice partners had established the 'Love Pudsey' charity to support health and social care professionals, patients and volunteers, the third sector and others to work together to address health and wellbeing challenges in the community of Pudsey. There was a board of trustees, which incorporated members of the practice, patients and local councillors.
- The practice had initiated the Practice Participation and Involvement (PPI) group. The PPI was registered as a foundation charitable trust of Robin Lane. The PPI had an active role in the delivery and future planning of services at the practice, which included supporting the patient volunteer programme.
- The practice held an annual general meeting where patients, volunteers and stakeholders were invited to attend. The latest meeting had been held in February 2016.

Summary of findings

The six population groups and what we found

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

Older people

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

- The practice offered proactive, responsive and personalised care to meet the needs of the older people in its population. Home visits, longer or urgent appointments were available for those in need.
- The practice had developed a Care of the Elderly pathway, aimed at those patients who were housebound, at a high risk of hospitalisation or residing in a care or nursing home. There was an 'elderly care team' in place and as a result the practice could evidence a 23% reduction in unplanned hospital admissions and an 80% reduction in urgent home visits for this population group.
- Patients were encouraged to attend the health and wellbeing centre and participate in the many events and activities being run there. For example, a weekly chair based exercise group run by one of the practice health care assistants.
- As part of the volunteer programme initiated by the practice, patients were supported with managing other aspects of life, such as using new technology including mobile phones and computer.

Outstanding



People with long term conditions

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

- Nursing staff had lead roles in the management of long term conditions.
- In line with best practice, six monthly or annual reviews were undertaken to check patients' health care and treatment needs were being met. For example: 92% of newly diagnosed diabetic patients had been referred to a structured education programme in the preceding 12 months (CCG average 88%, national average 90%); 100% of patients with diabetes had received an influenza vaccination (CCG and national average 94%)
- The practice pharmacist undertook a review of patients' medication to support optimisation and compliance.
- A register was maintained of those patients who were a high risk of an unplanned hospital admission. Individual care plans and support were in place for these patients.

Outstanding



Summary of findings

- The practice offered phlebotomy (blood tests) ambulatory blood pressure monitoring, spirometry and electrocardiogram (ECG) for patients as appropriate.
- There was a glaucoma diagnosis and monitoring service held in the practice.
- Patients were signposted to the health and wellbeing centre to access a range of activities suitable for patients with long term conditions. These included walking, exercise and lifestyle support groups.

Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances.
- The practice had recently reviewed its patient registration process to include a children's safeguarding screening process.
- Staff told us children and young people were treated in an age-appropriate way and were recognised as individuals and we saw evidence to confirm this.
- Appointments were available outside of school hours, on Saturdays and there a daily walk-in service, where priority was given to children and babies.
- The premises were suitable for children with a dedicated waiting area for children and parents and baby changing facilities.
- Two members of the clinical staff had extensive children's and adolescent mental health backgrounds and supported patients as needed.
- We saw evidence of monthly meetings between the health visitor and lead GP for safeguarding, to discuss vulnerable children and those with complex needs.
- The practice worked with midwives to support ante-natal and post-natal care.
- Uptake rates for all standard childhood immunisations were between 97% and 99%.
- At 79% the practice uptake for the cervical screening programme was in line with the CCG average of 75% and the national average of 82%.

Outstanding



Summary of findings

- The practice offered a sexual health clinic on Thursday afternoons. In addition there was a walk-in sexual health clinic available between 8am and 4pm on Saturdays. Nurses who were trained in sexual health and adolescent mental health supported the clinics.
- Patients had access to a breastfeeding support group and parent and toddler group based at the health centre.
- Teenagers were supported to use the smart app to access the practice, message a clinician or download health advice and information.

Working age people (including those recently retired and students)

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

- The needs of these patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice provided extended hours Monday to Saturday. Patients had access to the walk-in centre without the need to make an appointment.
- Telephone consultations and online services were available. This helped to improve access to the practice for this group of patients. The practice had 5,479 patients registered for online access which was 41% of the practice population.
- Patients of working age and students were encouraged and supported to use the smart app to access the practice, message a clinician or download health advice/information.
- The practice offered students MMR and Men C vaccinations. Students who were staying in the area for less than three months were supported to temporarily register with the practice.
- Sexual health services were offered which included contraceptive implants, coil fittings and chlamydia screening.
- Travel health advice and vaccinations were available.
- The practice offered free mindfulness classes for patients, which were accessible at the health and wellbeing centre.

Outstanding



People whose circumstances may make them vulnerable

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

- Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them

Outstanding



Summary of findings

vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

- The practice held a register of patients living in vulnerable circumstances including those who had a learning disability and patients who acted in the capacity of a carer.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. Vulnerable patients were supported to access various support groups and voluntary organisations
- The practice had a dedicated lead GP for those patients with a learning disability, who was responsible for ensuring that annual reviews were conducted. An alert was placed on the patient's electronic record so that staff and clinicians were aware of their vulnerability and potential increased patient requirement.
- The reception staff were trained to proactively identify patients who appeared to be distressed and alert a clinician as needed.
- Carers were offered a health check and influenza vaccination and were encouraged to participate in the Carers Leeds yellow card scheme. The practice facilitated a carers' support group which was held on a monthly basis. Details were displayed in the practice and also on their website.
- The practice signposted those patients who were lonely or isolated to other supportive services. The practice had previously hosted Christmas Day dinners for this group of patients.
- Through a public health campaign, the practice operated an annual Leeds wide outreach programme for those patients who were not currently registered with a GP practice. These patients were supported to register with the practice and referred to other health and social services as appropriate.

People experiencing poor mental health (including people with dementia)

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

- The practice regularly worked with multidisciplinary teams in the case management of people in this population group, for example the local mental health team.
- They had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Outstanding



Summary of findings

- Staff had a good understanding of how to support patients with mental health needs or dementia.
- Patients and/or their carer were given information on how to access various support groups and voluntary organisations.
- Data showed that 83% of patients diagnosed with dementia and 90% of patients who had a complex mental health problem, such as schizophrenia, bipolar affective disorder and other psychoses, had received a review of their care in the preceding 12 months. These were both in line with the CCG and national averages of 83% and 88% respectively.
- Health champions were available in the practice to support patients in this group.
- There were a variety of groups and activities available, such as art workshops, community choir and a 'singing for the brain' group.

Summary of findings

What people who use the service say

The national GP patient survey published in January 2016, distributed 265 survey forms of which 107 were returned. This was a response rate of 40% which represented less than 1% of the practice patient list. The results for the practice were variable compared to local CCG and national averages. For example:

- 84% of respondents described their overall experience of the practice as fairly or very good (CCG 89%, national 85%)
- 80% of respondents said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG 84%, national 79%)
- 69% of respondents described their experience of making an appointment as good (CCG 76%, national 73%)
- 85% of respondents said they found the receptionists at the practice helpful (CCG 89%, national 87%)
- 92% of respondents said they had confidence and trust in the last GP they saw or spoke to (CCG 97%, national 95%)
- 97% of respondents said they had confidence and trust in the last nurse they saw or spoke to (CCG 98%, national 97%)

The practice had also conducted a significant number of patient surveys totalling over 3,000 patient feedback forms. Overall, these showed patients were satisfied with the care and service they received.

As part of the inspection process we asked for Care Quality Commission (CQC) comment cards to be completed by patients. We received 21 comment cards all of which were positive about the standard of care received, although two were less positive regarding having to wait in the walk-in clinic.

We spoke with three patients in the waiting area. In addition, we also spoke with 22 members of the Practice Participation and Involvement (PPI) group, who were attending a meeting they were having at the time of our inspection.

All patients and PPI members spoke highly of the service and said they were satisfied with the care they received and thought staff were approachable, committed and caring. Comments were overwhelmingly positive and we were informed of many examples where they felt they received good care and service.

The people who used the wellbeing centre spoke very highly of the available activities, groups and the culture of the centre. The community café was seen as a very positive addition and the arts projects were welcomed.

Outstanding practice

- The practice had developed a Care of the Elderly pathway, aimed at those patients who were housebound, at a high risk of hospitalisation or residing in a care or nursing home. This pathway had been shared and implemented across other Leeds practices. They had developed an 'elderly care team' and as a result the practice could evidence a 23% reduction in unplanned hospital admissions and an 80% reduction in urgent home visits for this population group.
- There was a walk-in service for all routine or urgent health matters, which ran from 8am to 4pm Monday to

Saturday each week. There was evidence to support that there had been an overall reduction in A&E attendance by 10% and an overall reduced demand for appointments in the usual bookable clinics by 26%.

- The practice had developed the health and wellbeing centre where patients and members of the local community could attend. Facilities included an onsite café, arts events, a variety of support groups and over 60 free volunteer run activities.
- The practice promoted sharing and learning and linked with a number of organisations in this country and around the world to use best practice to develop their services. This was evidenced in the number of

Summary of findings

organisations who had approached the practice to share their innovative approach to primary care, such as the smartphone app, elderly care pathway and the formation of the health and wellbeing centre.

Robin Lane Health and Wellbeing Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and included a GP specialist adviser and a practice nurse specialist adviser.

Background to Robin Lane Health and Wellbeing Centre

Robin Lane Health and Wellbeing Centre is a member of the Leeds West Clinical Commissioning Group (CCG). Personal Medical Services (PMS) are provided under a contract with NHS England. At the time of inspection Robin Lane had been registered with the Care Quality Commission (CQC) as two separate entities Robin Lane Health Centre – Medical Wing and Robin Lane Health Centre - Charity Wing. At the time of publication of this report the practice have since registered as one entity – Robin Lane Health and Wellbeing Centre. The practice offers a range of enhanced services, which include:

- extended hours access
- improving patient online access
- delivering childhood, influenza and pneumococcal vaccinations
- facilitating timely diagnosis and support for people with dementia
- identification of patients with a learning disability and the offer of annual health checks
- identification of patients who are at a high risk of an unplanned hospital admission, reviewing and coordinating their care needs

- minor surgery
- a glaucoma diagnosis and monitoring service

The practice address is Robin Lane Health and Wellbeing Centre, Robin Lane, Pudsey LS28 7DE. There are good facilities for patients, who also have access to the full range of activities, groups and a café within the wellbeing centre. There is car parking and good transport links. There are plans in place to extend the current premises to include additional consulting rooms and patient/public areas.

The practice currently has a patient list size of 13,200, with higher than average numbers of patients under four years of age and those aged between 25 and 34. The percentage of patients who are in paid work or full time education is 71%, compared to CCG 66% and nationally 61%. Other patient demographics are comparable to CCG and national averages, for example 53% of patients had a long-standing health condition (CCG 51%, nationally 54%).

The partners consist of four GPs (one female, three male) and a non-clinical partner. Other clinical staff includes four salaried GPs (three female, one male), a female GP registrar, three ophthalmologists/specialists, a practice matron, four nurse practitioners, three practice nurses, one care of the elderly nurse, one eye specialist nurse, two practice health care assistants, two eye health care assistants, two eye technicians, one care of the elderly health care assistant, a pharmacist and a phlebotomist. The non-clinical team consist of three managers, three secretaries, one personal assistant, five clerical assistants, six receptionists, one reception technician and two housekeepers.

The practice opening hours are 8am to 8pm Monday to Friday and 9am to 4pm on Saturday. There are early morning appointments available on Wednesday from 7am.

Detailed findings

In addition there is a walk-in clinic available Monday to Saturday between 8am and 4pm, where patients can 'sit and wait' to be seen without the need for an appointment. Telephone consultations are also offered.

When the practice is closed out-of-hours services are provided by Local Care Direct, which can be accessed via the surgery telephone number or by calling the NHS 111 service.

The practice is a training practice for GP trainees (registrars) and supports graduate doctors, who are in their second year of a foundation programme (FY2), to gain experience in general practice. (This is a transition period of practice between being a student and undertaking more specialised training.) They also provide teaching practice and mentoring for third year medical students, nurse practitioner trainees and sixth form students. The practice also support a volunteer programme of patient volunteers, who deliver over 60 monthly health and wellbeing activities within the wellbeing centre.

The wellbeing centre is an integral part of the practice and can be accessed by patients and other members of the Pudsey community. The concept was initially developed by the practice in partnership with other organisations, such as Leeds City Council, with the aim of supporting the people of Pudsey to "live longer and healthier lives that are full, active and independent". A café is located within the centre for use both in the day and evening when events or activities are happening. Local groups can use the facilities free of charge and there are a range of event and activities available, such as live music sessions, theatre groups, displays of local art and walking groups. Other local Leeds services use the centre to host support groups, such as carers' support and counselling.

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 that we hold about the practice and asked other organisations, such as NHS England and Leeds West CCG, to share what they knew about the practice. We reviewed the latest 2014/15 data from the Quality and Outcomes Framework (QOF) and the latest national GP patient survey results (January 2016). QOF is a voluntary incentive scheme for GP practices in the UK, which financially rewards practices for the management of some of the most common long term conditions. We also reviewed policies, procedures and other relevant information the practice provided before and during the day of inspection. (Prior to publication we also reviewed the recently published QOF data for 2015/16.)

We carried out an announced inspection on 29 June 2016. During our visit we:

- Spoke with a range of staff, which consisted of two GP partners, a salaried GP, the managing partner, practice manager, facilities manager, practice matron, nurse practitioner, a health care assistant, a receptionist and the Arts in Health facilitator (who supports the events and activities held at the practice and wellbeing centre).
- Spoke with 22 members of the practice participation and involvement (PPI) group and three patients.
- Reviewed CQC comment cards and spoke with patients regarding the care they received and their opinion of the practice.
- Observed in the reception area how patients, carers and family members were treated.
- Looked at templates and information the practice used to deliver patient care and treatment plans.

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

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

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.

Are services safe?

Our findings

Safe track record and learning

There was a comprehensive and effective system in place for dealing with 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; which supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There was a comprehensive but easy to understand flowchart to remind staff of the reporting process.
- 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.
- A thorough analysis of significant events was carried out. Incidents were a standing agenda item at the clinical reference group meetings and we saw copies of formal minutes to evidence this. All incidents were discussed and included a three monthly follow-up progress report as appropriate. Staff were made aware of any actions or learning which arose from the incident.
- An annual end of year report of learning from incidents and significant events was produced and cascaded to all staff. We saw the latest 2015/16 report included a summary of findings and any identified themes, such as medicine related, patient confidentiality and health and safety at work.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, it had been discovered that a sharp item had been put into a clinical waste bin rather than a sharps bin. The significant event had led to a discussion within the practice and retraining for all clinical staff. Laminated instructions were displayed in all clinical areas and spot checks were carried out to ensure compliance was maintained.

Overview of safety systems and processes

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

- A comprehensive electronic risk register, which covered all aspects relating to risk management within the practice, such as health and safety, medicines management, equipment, business continuity, infection prevention and control and significant events. In addition, the register included all policies and a record of staff signing them, a matrix of staff training, staff immunisation details, dates and records of meetings, audits and areas of patient involvement. The register was reviewed and updated on a regular basis.
- Arrangements which reflected relevant legislation and local requirements were in place to safeguard children and vulnerable adults from abuse. Policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. There was a clinical lead for safeguarding adults and children. All GPs and nurses had been trained to level three safeguarding. Non-clinical staff were trained to level one. Staff could demonstrate their understanding of safeguarding. Although it was not always possible for the GPs to attend external multi-agency safeguarding meetings, reports were always provided where necessary. The health visitor attended a monthly safeguarding meeting and any child safeguarding issues or concerns were communicated to them. The practice had recently reviewed its patient registration process to include a children's safeguarding screening process.
- A notice was displayed in the waiting room, advising patients that a chaperone was available if required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) It was recorded in the patient's record when a chaperone had been in attendance or had been refused.
- The practice maintained appropriate standards of cleanliness and hygiene and we observed the premises to be clean and tidy. There was a nominated lead for

Are services safe?

infection prevention and control (IPC) and regular IPC audits were undertaken in line with guidance. We saw the action plan from the most recent audit undertaken in March 2016 and saw evidence that action had been taken to address any improvements. For example, the practice found the cleaning had not been undertaken to an acceptable standard. This had resulted in liaison with the cleaners, monthly spot checks and a three monthly compliance audit. Infection prevention and control was a regular agenda item for discussion at the practice meetings.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines, in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) A number of the nurses had qualified as independent prescribers and could, therefore, prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Health care assistants were trained to administer vaccines or medicines against a patient specific direction (PSD). (PSDs are written instructions for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- The practice employed a clinical pharmacist to support safe prescribing. They carried out regular medicines audits, to ensure prescribing was in line with best practice guidelines. They actioned Medicines and Healthcare products Regulatory Agency (MHRA) alerts and identified any patients who needed to be reviewed by the GP as a result. The pharmacist undertook medicine audits, which included emergency drugs and cold chain. It had been identified there are been poor stock rotation of vaccines. Systems had been put in

place to reduce any potential risk to patient safety and improve ordering and rotation of stock. A re-audit had shown significant improvements and adherence to the processes implemented.

- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

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 displayed 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 comprehensive range of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection prevention and control and legionella. (Legionella is a 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. There was a policy in place which stated how many staff could be on leave at any one time.

Arrangements to deal with emergencies and major incidents

The practice had suitable arrangements in place to respond to emergencies and major incidents. There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

- All staff were up to date with fire and basic life support training.

Are services safe?

- Emergency medicines, a defibrillator and oxygen (with adult and children's masks) were available in a secure area within the reception office. All staff knew of their location. There was also an emergency 'grab bag' available which contained all the information and equipment that may be required. At the time of our inspection all medicine and equipment we checked was in date, fit for use and stored securely.
- A first aid kit and accident book were available.
- 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 and all the partners had a copy.



Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care was delivered in line with best practice guidelines.

There were systems in place to keep all clinical staff up to date with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff had direct access to NICE guidance via a link on the practice computer system. NICE guidance was a standing agenda item at clinical meetings. We saw evidence that protocols had been reviewed to reflect any changes in NICE guidance, for example the use of ambulatory blood pressure monitoring in the diagnosis of hypertension (raised blood pressure).

The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

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.

The most recent published results at the time of inspection (2014/15) showed the practice had achieved 98% of the total number of points available, with 13% exception reporting. This was higher than the CCG and national average of 9%. Data for the 2015/15 QOF showed the practice had achieved 98% with 14% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Since the inspection the practice has provided us with data relating to 2015/16 QOF. They also informed us that the high number of care home patients, palliative care beds and patients at risk had impacted on their exception reporting due, in part, to their tolerance and adherence to medication regimes.

Data showed that the practice was an outlier for some QOF clinical targets:

- The percentage of patients with diabetes who had controlled blood pressure (BP) was 69%, (2015/16 data showed 72%) compared to CCG and national averages of 78%. However, the exception reporting was higher at 16% compared to CCG and national averages of 9% (2015/16 data showed the practice exception reporting as being 15%, compared to CCG and national average of 5%). This was discussed with the practice who considered they had under performed on BP control and over reported exceptions due to them believing they had a lower than expected prevalence.
- The percentage of patients with asthma who had received a review and assessment of symptom control in the preceding 12 months was 61% (2015/16 data showed 76%), compared to CCG and national averages of 75%. Exception reporting at 7% was the same as the CCG and national average.

However, the practice were performing higher than CCG and national averages for some domains, for example:

- The percentage of patients who were newly diagnosed with diabetes and had been referred to a structured education programme was 92%, compared to CCG average of 88% and national average of 90%. At 8% exception reporting was considerably lower than the CCG average of 38% and national average of 27%.
- The percentage of patients with schizophrenia, bipolar affective disorder or other psychoses and had a comprehensive agreed care plan in place was 90%, compared to CCG and national averages of 88%. At 8%, exception reporting in this area was lower than the CCG average of 11% and national average of 13%. (This group of patients can be difficult to engage due to their complex social and psychological needs.)

We saw formal minutes from meetings which showed QOF was discussed and any areas for action were identified (including those identified above). Each GP partner was allocated lead for specific areas of QOF. The managing partner was the lead for overall practice performance.

In March 2016 the practice had undertaken a QOF analysis review, which had looked at disease prevalence rates and QOF performance since April 2012. The review had shown an increase in the prevalence for many long term



Are services effective?

(for example, treatment is effective)

conditions, which included diabetes and asthma. The practice informed us they were continually evaluating themselves against other local practices and looked at continual improvements.

The practice used local and national benchmarking to improve quality. They benchmarked their performance against the local 'practice MOT' tool which compared data such as accident and emergency (A&E) attendance, referral rates and elective admissions across the practices in Leeds West CCG. These findings were discussed at clinical and practice meetings. The MOT tool showed that the practice was at the lower end of the spectrum for the number of A&E attendances, compared to other practices in the CCG.

There was evidence of quality improvement resulting from a programme of clinical audits. We saw there had been a number of audits completed in the last two years, some of which were two cycle where the improvements had been identified, implemented, monitored and maintained. We looked at several audits which included one relating to atrial fibrillation, which had showed an 8% improvement in patients being treated effectively with anti-coagulant medicine, such as warfarin.

From 2013, the practice had also undertaken an annual audit of patients who were at risk of developing diabetes. It showed all four stages of the audit cycle. The plan had been to increase awareness in all clinicians and improve diagnosis rates. As a result there had been a year on year increase in patients identified and placed on either the pre-diabetes or diabetes registers. All of these patients had been supported with managing lifestyle choices and preventative advice.

The practice pharmacist also undertook a programme of audit, which included emergency drug audit, cold chain compliance and prescription pad audit. All of which could evidence actions and improvements.

The practice participated in annual QIPP (Quality Improvement Productivity and Prevention) which provided an analysis of appointments, referral patterns, DNA (did not attend) rates and service performance. This information was broken down to an individual clinician level and was used to inform and influence behaviour and stimulate debate within the practice to improve service delivery. Individual information was also used to feed into the appraisal process. The QIPP report had also been used to effect internal change, such as the walk-in service.

Effective staffing

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

- The practice had a comprehensive recruitment policy in place. There was an induction programme for all newly appointed staff which covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Staff received mandatory 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. Doctors were given protected learning time to undertake mandatory e-learning sessions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online 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, clinical supervision and facilitation and support for GP revalidation.
- There was an appraisal process in place. Appraisals took place on a quarterly basis for all clinical and non-clinical staff and included training and development plans for individuals. We saw that all appraisals were up to date and could evidence staff involvement and records of their comments on the appraisal form. Staff informed us they felt supported through the appraisal process and that clinical supervision was easily accessible; particularly for the independent nurse prescribers.
- We were informed, and saw evidence, that all new health care assistants were supported to undertake the Cavendish Care Certificate programme. (This aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care.)

Coordinating patient care and information sharing



Are services effective?

(for example, treatment is effective)

The practice had timely access to information needed, such as medical records, investigation and test results, to plan and deliver care and treatment for patients. They could evidence how they followed up patients who had an unplanned hospital admission or had attended A&E. Care plans were in place for those patients who had complex or palliative care needs or were at a high risk of an unplanned hospital admission. These were reviewed and updated as needed. Information regarding end of life care was shared with out-of-hours services, to minimise any distress to the patient and/or family.

Staff worked with other health and social care services, such as the community matron and palliative care nurse, to understand and meet the complexity of patients' needs and to assess and plan ongoing care and treatment. With the patient's consent, information was shared between services using a shared care record. We saw evidence that multidisciplinary team meetings, to discuss patients and clinical issues, took place on a monthly basis.

The practice had been an early implementer of a proactive and planned approach to providing elderly care. They had developed a Care of the Elderly pathway, aimed at those patients who were housebound, at a high risk of hospitalisation or were residents in a care or nursing home. This pathway had subsequently been shared nationally and implemented across other Leeds practices. There was an 'elderly care team' comprising of a GP, pharmacist, practice matron and a care of the elderly trained nurse and health care assistant. Patients had tailored individualised care plans in place to maximise health outcomes and quality of life. Practice staff case managed residents of the care/nursing homes in partnership with care home staff. The practice had reviewed the impact of these interventions over the last ten years and could evidence there had been a 23% reduction in unplanned admissions and an 80% reduction in urgent home visits.

Consent to care and treatment

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

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

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

Supporting patients to live healthier lives

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

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

At 79%, the 2014/15 date showed the practice uptake for the cervical screening programme was in line with the CCG average of 75% and national average of 82%. The data for 2015/16 showed an increase in uptake to 82% (compared to CCG 79% and national 82%). There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages, pictorial leaflets for those with a learning disability or unable to comprehend written words. They ensured there was always a female sample taker available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national cancer screening programmes. The uptake rates for bowel screening was 60% (CCG and national 58%) and the uptake rates for breast screening was 76% (CCG 69%, national 72%).



Are services effective?

(for example, treatment is effective)

Childhood immunisation uptake rates were comparable to CCG averages. For example, immunisation given to children 24 months and under ranged from 97% to 99% and five year olds from 93% to 99% (CCG 96%).

Patients had access to appropriate health assessments and checks. These included NHS health checks for people aged 40 to 75. Where abnormalities or risk factors were identified, appropriate follow-ups were undertaken.

Patients and members of the Pudsey community had access to a wide range of group activities provided each month at the wellbeing centre. These activities included chair based exercise, Dementia Singing for the Brain and ukele groups.

Patients had access to a consultant-led ophthalmology service facilitated by Robin Lane Health and Wellbeing Centre. This supported a reduced need to attend secondary care services. Patients' feedback regarding this service was very positive.

We saw evidence that two mental health organisations had conducted reviews of the practice's approach to working with people experiencing mental health challenges. Specifically, they focused on the work carried out between the practice and its patient volunteers. The review showed that as a result of the practice patient volunteer program to improving health and wellbeing:

- 78% had increased knowledge of ways to improve mental wellbeing and happiness
- 70% said they felt happier
- 68% said they had increased self-confidence
- 85% said they made more friends
- 71% said they had more contact with people in the community

Through a public health campaign, the practice operated an annual Leeds wide outreach programme for those patients who were not currently registered with a GP practice. These patients were supported to register with the practice and referred to other health and social services as appropriate. In the period between July and November 2015, a number of patients had been registered with the practice, many of whom were found to have an existing medical issue or long term condition. For example, 19 had chronic obstructive pulmonary disease, 19 had diabetes and 29 had dementia. These patients were all provided care, treatment, support and referred to other services as appropriate. Six children and five adults who were registered during this time were found to have a safeguarding concern and were placed on the safeguarding register.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that:

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

Results from the national GP patient survey showed respondents rated the practice as being comparable to CCG and national averages for many questions regarding how they were treated. For example:

- 88% of respondents said the last GP they saw or spoke to was good at listening to them (CCG 90%, national 89%)
- 81% of respondents said the last GP they saw or spoke to was good at giving them enough time (CCG 88%, national 87%)
- 84% of respondents said the last GP they spoke to was good at treating them with care and concern (CCG 88%, national 85%)
- 94% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG 92%, national 91%)
- 96% of respondents said the last nurse they saw or spoke to was good at giving them enough time (CCG 94%, national 92%)
- 96% of respondents said the last nurse they spoke to was good at treating them with care and concern (CCG 93%, national 91%)

The patient survey had been discussed at a practice meeting and the feeling was that many of the lower responses related to the walk-in service. The practice were

continually looking at ways to improve the patient experience, particularly those attending the walk-in. However, patients we spoke with on the day were positive about the practice and the walk-in service.

Care planning and involvement in decisions about care and treatment

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

- Interpretation and translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- The choose and book service was used with all patients as appropriate. This allowed the patient the opportunity to opt for treatment at a hospital of their choice and at a time suitable for them.
- Care plans were personalised and developed in conjunction with the patient.

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 variable compared to with local and national averages. For example:

- 75% of respondents said the last GP they saw was good at involving them in decisions about their care (CCG 84%, national 82%)
- 85% of respondents said the last GP they saw was good at explaining tests and treatments (CCG 88%, national 86%)
- 84% of respondents said the last nurse they saw was good at involving them in decisions about their care (CCG 86%, national 85%)
- 93% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG 91%, national 90%)

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

Patient and carer support to cope emotionally with care and treatment

Are services caring?

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

The practice maintained a carers' register and the patient electronic record system alerted clinicians if a patient was a carer. At the time of our inspection the practice had identified 195 carers, which equated to almost 2% of the practice population. All carers were offered a health check and influenza vaccination. Carers were encouraged to participate in the Carers Leeds yellow card scheme. (This card informed health professionals that the individual is a carer for another person should the carer become ill, have an accident or be admitted to hospital.) The practice facilitated a carers' support group which was held on a monthly basis. Details were displayed in the practice and also on their website.

The practice worked jointly with palliative care and district nursing teams to ensure patients who required palliative care, and their families, were supported as needed. We saw evidence of care planning to support end of life care. Staff told us that if families experienced the bereavement of a registered patient a condolence card was sent and a GP appointment was offered. There was information in the practice and on the website regarding bereavement and counselling services.

The practice signposted those patients who were lonely or isolated to other supportive services. We were informed the practice had previously hosted and funded a Christmas Day dinner for this group of patients, which had been positively welcomed and attended.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice regularly reviewed the needs of its local population and engaged with the NHS England Area Team and Leeds West Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. People's individual needs and preferences were central to the planning and deliver of tailored services. Services provided choice, were flexible and helped to support continuity of care:

- The practice offered extended hours until 8pm Monday to Friday and from 7am on Wednesdays. In addition they were also open 8am to 4pm on Saturdays.
- There was a walk-in service for routine or urgent health matters, which ran from 8am to 4pm Monday to Saturday each week.
- There were longer appointments available for patients with a learning disability, a mental health issue or who were elderly.
- Telephone consultations were available with either a GP or nurse.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Mobile phone text reminders were sent to patients and patients could cancel their appointment by text. This service had resulted in a decrease in the number of patients who failed to attend for their appointment.
- Online access for the booking of appointments and making prescription requests was available. At the time of inspection, there were 5,479 patients registered for online access which equated to 41% of the practice population.
- The practice had developed a smartphone app that enabled patients to request appointments, order prescriptions, send secure messages to clinicians, record their own health issues or view health information videos. We were informed by the practice that the app was widely used and had been effective in reaching patients who may not ordinarily interact with GP services.
- There were disabled facilities, a hearing loop and interpretation services available.
- Patients had access to a dermatology review service run by a specialist dermatology nurse practitioner, which reduced the need for patients to attend a secondary care service.
- There was a glaucoma diagnosis and monitoring service held in the practice.
- The practice facilitated a Leeds wide ophthalmology service each weekday and occasionally on a Saturday, as needed. Again, this reduced the need for patients having to travel to a secondary care service.
- A sexual health clinic was available on Thursday afternoons. In addition there was a walk-in sexual health clinic available from 8am to 4pm on Saturdays. Nurses who were trained in sexual health and adolescent mental health supported the clinics.
- The practice had developed the health and wellbeing centre, where patients and members of the local community had access to a range of facilities, events and activities to support healthy lifestyle and socialisation. Facilities included an onsite café, arts events and over 60 free volunteer run activities.
- The practice hosted a Physio First service, which was a general physiotherapy service to support patients who had musculoskeletal problems.

Access to the service

People could access appointments and services in a way and at a time that suited them. The practice was open between 8am to 8pm Monday to Friday, from 7am on Wednesday and 8am to 4pm on Saturday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Patients had access to a walk-in service for all routine or urgent health matters, which ran from 8am to 4pm Monday to Saturday each week. Attention given to patient education during attendance supported patients to self-manage episodes of minor illness. There was evidence to support there had been an overall reduction in A&E attendance by 10%, resulting in part from patient access to the walk-in service. A review of the service had shown that there had specifically been a 9% reduction in A&E attendance in December 2015 and a 13% reduction in January 2016. (During this period the Leeds A&E departments had seen a significant increase of overall attendance.)



Are services responsive to people's needs?

(for example, to feedback?)

The practice had undertaken an audit of average waiting times for the walk-in service, which was on average 30 minutes. When patients book into the walk-in clinic they are given an estimated length of wait and can leave the surgery and return for their appointment if they wish. As a result of a review of the service demand the practice had implemented a work plan which specified the number of clinicians needed to provide a full and sustainable walk-in service. The practice were continually reviewing the service to ensure its effectiveness and responsiveness.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment were variable compared to local and national averages.

- 91% of patients were satisfied with the practice opening hours (CCG 83%, national 77%)
- 69% of patients said it was generally easy to get through to the practice by telephone (CCG 77%, national 73%)
- 93% of respondents said the last appointment they got was convenient (CCG 93%, national 92%)

Patients we spoke with on the day of the inspection and comments we received, told us they were able to get appointments when they needed one and felt there was good access to the practice.

Listening and learning from concerns and complaints

The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. We saw that information was available to help patients understand the complaints system. There were posters and leaflets in the waiting area and information on the practice website.

We viewed the complaints report for 2015/16, of which there had been 45 complaints in total. The practice undertook an annual review of complaints and we saw there was evidence of analysis of themes and trends, and actions taken to learn from the complaint and prevent any reoccurrence. The practice informed us they were continual looking to improve and learn from complaints received from patients. They acknowledged that the introduction of the walk-in service had caused frustration with some patients regarding waiting times to be seen.

We looked at six complaints in detail and found they had been satisfactorily handled and dealt with in a timely, open and transparent manner. For example, a new patient had not been registered on the practice system, which had resulted in a delay in being seen. Consequently, all reception staff had undergone retraining on the registration process. Additionally, a new patient registration pathway had been developed which also included an improved identification tool of any safeguarding concerns which may arise during registration.

Are services well-led?

Outstanding



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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. They were innovative and included a commitment to providing proactive and extended primary care services, such as the community eye clinic and wellbeing centre, in collaboration with people outside of the practice.

The practice strategy and supporting objectives were challenging and innovative, whilst remaining achievable. They had produced a four year strategy document entitled 'Reimagining General Practice 2016 to 2020', which identified their vision, mission and values and how they would be delivered. The strategy had been developed in collaboration with staff, patients and stakeholders. It contained details covering the practice demographics, patient survey responses, recent innovations, the case for change, building blocks and key principles. In addition, information was provided regarding future workshops and development where staff, patients and stakeholders were encouraged to be involved. The strategy document was available in the practice and on their website. All staff were signed up to the delivery and understood their roles and responsibilities in doing so.

Governance arrangements

There were systems in place to enable good governance and oversight, which were highly effective in allowing the partners to assess quality and identify and mitigate risk whilst driving improvements in services. Governance and performance management arrangements were proactively reviewed and reflected best practice. We saw evidence of:

- A clear staffing structure and that staff were aware of their own roles and responsibilities. Staff were supported through meetings, training and appraisals.
- Practice specific policies were implemented and embedded. They were available to all staff who had signed to say they had seen them.
- This was demonstrated in the management of patients who were at risk of an unplanned hospital admission and the ongoing review of learning from significant events.
- Continuous monitoring of effectiveness when new ways of working were implemented. This ensured resources

were allocated accordingly, patient health care needs were met and patient experience maximised. This could be demonstrated in the care of the elderly pathway and the walk-in service.

- There was a programme of continuous audit used to monitor quality and make improvements.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Staff worked in collaboration to deliver a safe, effective and responsive service.
- The practice held regular team meetings, which included the partnership board, clinical reference group and a palliative care group. We saw that all meetings had terms of reference and formal minutes with actions logged.

Leadership and culture

The partners in the practice had the shared aim to drive the practice forward and motivate their staff to succeed. All staff we spoke with told us the partners were approachable and took the time to listen to them. There was a clear leadership structure in place and staff felt supported by management. They told us:

- There was an open culture within the practice and they had the opportunity to raise any issues at the team meetings and felt confident and supported in doing so.
- They were involved in discussions about how to develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. This included support and training for all staff on communicating with patients about notifiable safety incidents. The practice had systems in place to ensure that when things went wrong with care and treatment:

- Affected people were given reasonable support, truthful information and a verbal and written apology
- Written records of verbal interactions as well as written correspondence was kept.

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

The practice proactively sought, encouraged and valued feedback from patients, the public and staff regarding the

Are services well-led?

Outstanding



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

delivery and development of services. We saw there was strong collaboration and supportive ethos across all staff, with a common focus on improving the quality of care and patients' experiences:

- Feedback was gathered from patients through patient engagement workshops and the Practice Participation and Involvement (PPI) group. The PPI was registered as a foundation charitable trust of Robin Lane. We were informed that the PPI had a very active role in the delivery and future planning of services at the practice. There were over 50 members, some of whom also acted as volunteers within the practice and wellbeing centre.
- The practice held an annual general meeting where patients, volunteers and stakeholders were invited to attend. The latest meeting had been held in February 2016.
- The practice had conducted a significant number of patient surveys totalling over 3,000 patient feedback forms.
- We saw evidence of actions taken by the practice as a result of patient feedback. For example, patients had wanted improved access to urgent appointments. Changes were made to the walk-in service to facilitate this. These included making an adjustment to staffing levels and providing information regarding quiet and busy times to support patients making a choice in when they attend the practice. Patients had reported improved satisfaction in waiting times as a result of the changes.
- There was a high level of constructive engagement with staff, which was evidenced in their Staff Engagement Exercise which took place in January/February 2016. This had been facilitated by an external consultant. The outcomes had included an action plan and showed that staff felt valued and positive about the practice. The results from this exercise had also fed into the four year strategy document.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and looked to improve outcomes for patients, but also other residents in the local community.

There was strong evidence of practice and community collaboration. In 2013, the practice partners established the 'Love Pudsey' charity to support health and social care professionals, patients and volunteers, the third sector and others to work together to address health and wellbeing challenges in the community of Pudsey.

As a result of the development of the smartphone app, the practice had been a finalist in the GP Enterprise Awards 2013 in the 'best use of media and technology' category and had won the category of 'improving quality and productivity' in relation to their walk-in service. The practice were continually evaluating and reviewing how improvements could be made to service delivery in order to improve patient outcomes and satisfaction.

The practice had also been used as an example of excellence in publications such as the General Practice Forward Review April 2016 (published by NHS England); Mental Health in Primary Care, a briefing for CCG June 2016 (published by MIND).

A systematic approach was taken to working with other organisations to improve care outcomes and share best practice. The practice promoted sharing and learning through links with a number of organisations in this country and around the world to use best practice to develop their services and have shared their experiences with local, national and international organisations. For example, universities and public health institutes in England, Canada and Hungary.