City View Medical Practice

Quality Report

Beeston Hill Community Health Centre (Floor 1)
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Website: www.cityviewmedicalpractice.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at City View Medical Practice on 3 August 2017.

Overall the practice is rated as good. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. We saw that incidents and events were analysed and learning shared with others; both in the practice and with the local Clinical Commissioning Group.
- The practice had clearly defined and embedded systems to minimise risks to patient safety. They responded quickly to areas of identified risk.
- The practice delivered enhanced services or participated in programmes, to meet the needs of their patient population.
- The practice had identified that 31% of their patients had a mental health issue. As a result, they had employed a mental health specialist nurse, who provided additional support for those patients. This model of working had been shared with other practices within the Leeds South and East Clinical Commissioning Group (CCG).
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. They effectively utilised current best practice and guidance.
- Patients we spoke with said they were treated with compassion, dignity and respect.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The practice had good governance arrangements in place. There was strong and visible clinical and managerial leadership and staff said they felt supported.

Summary of findings

- The practice had undergone a period of change which had supported continued improved services for patients. The practice had a strong vision, which included working with patients to support the delivery of high quality care and treatment.

We saw several areas of outstanding practice:

- There was involvement with the wider community, through the use of the patient participation group, the volunteer practice health champions and the practice allotment. The allotment was used to promote health and well-being of patients. Any produce grown in the allotment was made available to patients within the practice.
- The practice was recognised by the CCG as being a good example of best practice in promoting bowel cancer screening with patients. We were informed of the "gold standard service" which was offered by the practice.

The area where the provider should make an improvement is:

- Embed the revised processes regarding emergency equipment and medicines.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information and a written apology. It was noted that the practice was seen positively as one of the highest reporters of incidents to the local Clinical Commissioning Group.
- The practice had clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse. Staff demonstrated that they understood their responsibilities and all had received training, relevant to their role, on safeguarding children and vulnerable adults.
- Risk management was comprehensive, embedded and recognised as the responsibility of all staff. The practice monitored and analysed trends in significant events, complaints and performance indicators to drive continuous improvement.
- The practice had arrangements in place to respond to emergencies and major incidents. At the time of inspection we found that another GP practice in the building also used some of the emergency equipment owned by the practice. This could mean potential difficulty in access to equipment at times of emergency. Following our feedback, the practice provided evidence that this issue had been resolved within two working days of the inspection.

Are services effective?

Good

The practice is rated as good for providing effective services.

- There were systems to ensure that clinicians utilised national and locally agreed guidelines, to positively influence and improve outcomes for patients. Staff were supported to develop their skills and knowledge to deliver effective care and treatment.

Summary of findings

- The practice ensured that patients with complex needs, including those with life-limiting conditions or reaching end of life, were supported to receive co-ordinated care. They worked with other health and social care professionals to provide appropriate care and treatment.
- There was involvement with the wider community, through the use of the patient participation group, the practice health champions and the practice allotment.
- The practice was recognised by the CCG as a leading practice in promoting bowel cancer screening with its patients.
- There was evidence of appraisals and personal development plans for all staff.
- Clinical audits, including medicine audits, and reviews were undertaken, to ensure patients received appropriate treatment in line with clinical guidance.
- Data from the Quality and Outcomes Framework (QOF) referred to in this report refers to a period prior to the current provider. It shows the practice was performing in line with local and national averages. The practice was currently undertaking work in line with the 2017/18 QOF.

Are services caring?

Good

The practice is rated as good for providing caring services.

- The practice had a patient-centred culture and we observed that staff treated patients with kindness, dignity, respect and compassion.
- The practice held a carers' register and provided health checks and influenza vaccinations for those patients. Carers were issued with a pack, which contained a variety of information how to access additional support and benefits.
- Regular carers' events were held at the practice. The practice health champions also provided support for carers or those recently bereaved.
- Data from the most recently published national GP patient survey related to the previous provider. However, the practice had recently undertaken their own patient survey, with could demonstrate an improvement in patient satisfaction.
- Patients we spoke with on the day, and comment cards received, showed they were treated with compassion, dignity and respect.
- Information for patients about the services available was accessible and in languages befitting the majority of the patient population. Some of the practice staff were multi-lingual

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice had a good understanding of their patient population and provided services to meet the needs of patients. For example, the employment of a mental health specialist nurse.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- The practice had reviewed access and implemented a triage system to support patients who needed to be seen the same day as requested.
- Extended hours were available on Wednesdays and Thursdays.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from the ones we reviewed showed 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.

- The practice had undergone a period of change which had supported continued improved services for patients. The practice had a strong vision, which included working with patients to support the delivery of high quality care and treatment.
- The practice had strong and visible clinical and managerial leadership. Staff were aware of how the provider and the practice worked together, as well as understanding their individual roles and responsibilities.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There were reviews and analysis of patient feedback, significant events and performance outcomes.
- The practice encouraged a culture of openness and honesty. There were systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken. They were aware of the requirements of the duty of candour.
- There was good teamwork and high standards were promoted and owned by all the staff.

Summary of findings

- There was a strong focus on continuous learning and development at all levels. The practice had revised their induction programmes. Staff participated in annual performance reviews and attended staff meetings.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on.
- The patient participation group was very active and supported practice development.
- Communication channels and meetings had been streamlined to improve effectiveness and efficiency. A structure of internal meetings was embedded, to ensure information and learning was disseminated and feedback gathered proactively.
- The practice was proactively succession planning their workforce in order to maintain the delivery of services for evolving patient care needs.
- The model of care delivered by the practice, in conjunction with the provider, was being evaluated with a possibility of it being offered to other practices, as appropriate.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population. Although the avoiding unplanned admissions enhanced service had been discontinued, the practice continued to treat frail patients as a priority. They carried out care planning and reviews as appropriate.
- The practice liaised with other health and social care professionals and, with the patient's consent, shared care records to support an appropriate package of care.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. Patients were involved in planning and making decisions about their care.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- In collaboration with local practices, they participated in the falls prevention scheme. They identified patients who were at a high risk of a fall and provided appropriate interventions to reduce the risk.
- Weekly 'ward rounds' were undertaken at two local care homes, where some patients resided. Regular reviews of patients' care and treatment were carried out.
- The practice was an early adopter of a Leeds project, which used a multidisciplinary approach in providing holistic care for moderate to severely frail patients.

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 long term disease management.They were receiving additional training, to support the provision of seamless care and avoid the need for multiple appointments.
- All these patients had a structured annual review, at a minimum, to check their health and treatment needs were being met.

Summary of findings

- Patients who were on high risk medicines were reviewed in line with guidance.
- Patients who were at risk of hospital admission were identified as a priority.
- The practice followed up on patients with long term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long term conditions who experienced a sudden deterioration in health.
- There was a clinical lead for quality outcomes relating to long term conditions.

Families, children and young people

Good

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

- From the sample of documented examples we reviewed, we found there were systems 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 accident and emergency (A&E) attendances.
- The uptake for childhood immunisations was higher than local and national averages.
- We observed that staff treated children and young people in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- A letter was sent to children just before their 16th birthday. This contained advice on how to access the practice services independently and assured them of confidentiality.
- A separate, private, room was available for mothers who wished to breastfeed.
- In response to patient feedback, the practice had provided activities in the waiting room for children, such as books.

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).

Summary of findings

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and the triage system.
- The practice was proactive in offering online services, which included the ability to book an appointment or request a prescription.
- The practice promoted a full range of health promotion and screening that reflected the needs for this age group.
- Patients had access to an early morning phlebotomy clinic, to reduce the need for taking time off work.

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.

- There was a system in place to identify those patients living in vulnerable circumstances, including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for those patients who had a learning disability or complex health need.
- The practice worked with the local community learning disabilities team to improve the uptake of health reviews, and make the service more accessible to this group of patients.
- End of life care was delivered in a co-ordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- A local drug and alcohol service held a weekly clinic at the practice, where patients with substance misuse issues could access help, advice and support.
- Staff could demonstrate a good understanding of assessing mental capacity.

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 was registered as being dementia friendly, with staff having undergone specific training in dementia.

Summary of findings

- Those patients who had dementia received an annual review of their care, either at the practice or at their place of residence; depending on need. Advanced care planning was also undertaken with these patients.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had identified a higher number of patients who had mental health needs, compared to local and national averages. As a result they had employed a mental health specialist nurse, who supported patients, undertook health reviews, provided brief interventions and coping strategies. This model of working had been shared with other practices within the Leeds South and East Clinical Commissioning Group.
- The practice regularly worked with multidisciplinary teams in the case management of patients experiencing poor mental health, such as community mental health services.
- There was information available both in the practice and on the website on how patients could access other avenues of support, such as local voluntary organisations or support groups.
- Performance for mental health related indicators was higher than CCG and national averages. For example, 100% of patients who were currently being prescribed lithium (medication used to treat the manic episodes of bipolar disorder) had undergone appropriate blood tests in the preceding 9 months, compared to the CCG and national averages of 97%.
- There was a system in place for monitoring repeat prescribing for patients receiving medicines for mental health needs.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published on 7 July 2017, and related to questionnaires sent out in January 2017 (which was prior to the current provider taking over the practice). The results showed the practice was generally performing in line with local and national averages. However, there were some areas where the practice performed below those averages.

Of the 329 survey forms which were distributed, 90 were returned, which gave a response rate of 27%. This represented less than 1% of the practice's patient list.

- 81% of patients said they found the receptionists at the practice helpful; compared to the CCG average of 85% and the national average of 87%.
- 79% of patients described the overall experience of this GP practice as good (CCG 85%, national 85%).
- 69% of patients said they would recommend this GP practice to someone who has just moved to the local area (CCG 74%, national 77%).

The practice had recently undertaken their own patient survey (June 2017), which had been conducted by the patient participation group. There had been 161 respondents and the results had shown an improvement in patient satisfaction, for example:

- 93% of patients said they found staff to be friendly and approachable.
- 83% of patients said they would recommend the practice to friends and family.

We were informed by the practice that they were hoping to improve patient satisfaction regarding clinicians, as they had increased the numbers of clinicians employed. They were now able to provide a stable workforce to support continuity of care.

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 18 comment cards, 17 of which were positive. One patient specifically commented that they felt the practice had recently improved. Many commented on the good care and service they received from clinicians. They said they found the reception staff friendly and helpful.

We spoke with 15 patients during the inspection. These were a mixture of male, female, different ages and countries of origin, such as Mongolia, Pakistan, New Guinea and Romania. Thirteen patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Two patients thought this varied. In addition, some patients said they thought that reception staff were "very good at handling challenging behaviour" displayed by some people who used the service.

Regarding access, three patients said they had found it difficult getting through to the practice by telephone (this was generally at 8am). The remaining patients said it could vary, but were generally satisfied.

The results of the most recent Friends and Family Test (FFT) showed that out of 138 respondents, 83% (115) said they would be extremely likely or likely to recommend the practice to friends and family if they needed care or treatment. The rest of the respondents did not state whether they would or would not make a recommendation. (FFT is a national test created to help service providers and commissioners understand whether their patients were happy with the service provided.)

Areas for improvement

Action the service SHOULD take to improve

Embed the revised processes regarding emergency equipment and medicines.

Summary of findings

Outstanding practice

- There was involvement with the wider community, through the use of the patient participation group, the volunteer practice health champions and the practice allotment. The allotment was used to promote health and well-being of patients. Any produce grown in the allotment was made available to patients within the practice.
- The practice was recognised by the CCG as being a good example of best practice in promoting bowel cancer screening with patients. We were informed of the "gold standard service" which was offered by the practice.

City View Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included a GP specialist adviser, a second CQC inspector and an Expert by Experience.

Background to City View Medical Practice

City View Medical Practice is a member of the Leeds South and East Clinical Commissioning Group (CCG). Personal Medical Services (PMS) are provided under a contract with NHS England. They also offer a range of enhanced services, which includes:

- extended hours access
- delivering childhood, meningitis, influenza and pneumococcal vaccinations
- facilitating timely diagnosis and support for people with dementia
- provision of annual health checks for those patients who have a learning disability

The practice is located in leased premises on the 1st Floor of Beeston Hill Community Health Centre, 123 Cemetery Road, Leeds LS11 8SU. There is a separate GP practice on the 2nd floor of the building and community services based on the ground floor. There is a large car park with designated disabled parking. The practice is close to transport links.

Information published by Public Health England rates the level of deprivation within practice population groups on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. People living in more deprived areas tend to have a greater need for health services. City View Medical Practice is assessed as being level one.

There are currently 11,901 patients registered with the practice (the CCG average being 6,648). The patient population consists of approximately 40% who don't have English as a first language. It is noted that there are over 100 different languages spoken by patients who are registered with the practice; as their origins are Asia, Africa or eastern Europe. Published data shows that some of City View Medical Practice's patient demographics deviate from local and national statistics. For example:

- there are higher numbers of patients who are aged between 0 to 40 years
- 70% of patients are in paid work or full-time education (CCG and national 62%)
- 10% of patients are unemployed (CCG 6%, national 4%)
- 21% of patients are living with dementia (CCG 12%, national 13%)
- 31% of patients have a mental health condition (CCG and national 11%)

There are six salaried GPs (one male, five female), two female advanced nurse practitioners and a female specialist nurse practitioner in mental health. The nursing team consists of four practice nurses and three healthcare assistants; all of whom are female. There is a practice management team consisting of a practice manager, assistant practice manager and patient services team manager. These are all supported by an experienced team of administration and reception staff. The practice employs a pharmacist and a CCG pharmacy technician also attends the practice one day per week.

Detailed findings

City View Medical Practice is open from 8am to 6.30pm Monday to Friday. Extended hours are available on Wednesdays from 7am and Thursdays from 7am to 7.30pm. Appointments are offered at the following times:

Monday: 8.10am to 12.30 pm and 1pm to 5.40pm

Tuesday: 8.10am to 12.30 pm and 1pm to 5.40pm

Wednesday: 7.10am to 6.30pm

Thursday: 7.10am to 7.10pm

Friday: 8.10am to 12.30 pm and 1.30pm to 5.50pm

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

The practice has good working relationships with local health, social and third sector services to support provision of care for its patients. (The third sector includes a very diverse range of organisations including voluntary, community, tenants' and residents' groups.)

City View Medical Practice is a teaching and training practice. They are accredited to train qualified doctors to become GPs (registrars).

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as Leeds South and East Clinical Commissioning Group (CCG), NHS England and Healthwatch, to share what they knew.

We carried out an announced visit on 3 August 2017. During our visit we:

- Spoke with a range of staff; which included GPs, advanced nurse practitioner, mental health specialist nurse, practice pharmacist, practice nurse, health care assistant, practice manager and assistant practice manager.
- Spoke with a CCG health improvement practitioner, in relation to the practice promotion of bowel cancer screening.
- Spoke to patient participation group members and also practice health champions.
- Spoke with patients who used the service.
- Reviewed questionnaire sheets which had been completed prior to inspection by nursing, administration and reception staff.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed a sample of the personal care or treatment records of patients.
- Observed how patients/carers/family members were treated when attending or telephoning the practice.
- 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 were provided for specific groups of people and what good care looked like for them. The population groups are:

- older people
- people with long term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

Detailed findings

The practice had recently undergone a change in provider, which had arisen through a reduction of the number of GP partners. Consequently, the published data referred to in this report for the Quality and Outcomes Framework (QOF) and national patient survey refers to a period of significant change at the practice.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, there had been a few incidents involving members of the public using the practice toilets in relation to substance misuse. Staff had found used syringes on several occasions. On one occasion the police had been involved regarding a knife being found in the toilet. We saw that these incidents had all been recorded appropriately. Meetings had taken place within the practice and with the landlord and other providers who worked within the health centre, who had also experienced similar issues. As a result it had been universally agreed to keep the toilets locked and patients had to request the access keys from the practice reception area. This had proved to be an effective solution and the practice had not received any complaints from patients as a result of the change.
- From the sample of incidents we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We saw that the practice also monitored themes/trends in significant events and evaluated any actions that had been taken.
- It was noted that the practice was seen positively as one of the highest reporters of incidents to the local CCG. All practices were actively encouraged to report any incidents onto an electronic local and national database.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- We saw evidence of a comprehensive system and processes in place for dealing with patient safety alerts. The assistant practice manager co-ordinated the alerts and recorded what actions were taken and who was responsible on a continuing spreadsheet. The practice pharmacist actioned any alerts relevant to medicines, these were also recorded on the spreadsheet. This provided an auditable trail.
- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare.
- The practice had systems in place to protect vulnerable adults and children in relation to safeguarding. For example, looked after children had their identities protected on the appointment call system, to prevent other patients seeing their names.
- Safeguarding was discussed in the monthly governance meeting and bi-monthly meetings were held with the named health visitor for the practice.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. All staff had received vulnerable adult and child safeguarding training at an appropriate level for their role. The identified GP safeguarding lead was trained to level three.
- Notices were displayed in all the consulting and treatment rooms, advising patients that chaperones were available if required. (A chaperone is someone who serves as a witness for both a patient and a medical professional and acts as a safeguard for both parties during an intimate medical examination or procedure).
- All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service

(DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. Patients we spoke with also commented positively on the cleanliness of the practice.
- There were cleaning schedules and monitoring systems in place. Cleaning was carried out by an external contractor who had responsibility for the whole building.
- An advanced nurse practitioner (ANP) was the clinical infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. The practice manager was the non-clinical IPC lead. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken; the most recent was February 2017 and had been updated in July 2017. We saw documented evidence that action had been taken to address any improvements identified as a result.

There were arrangements in place for managing medicines, including emergency medicines and vaccines, in the practice (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions, which included the review of high risk medicines. Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- The ANPs and a practice nurse had qualified as independent prescribers and could prescribe medicines for clinical conditions within their expertise. They received weekly mentorship and support from the medical staff for this extended role.
- The practice employed their own pharmacist, who carried out regular medicines audits, to ensure prescribing was in line with best practice guidelines for safe prescribing. A member of the local CCG pharmacy team also attended the practice one day per week, to provide additional support.
- Patient Group Directions 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.)
- Healthcare 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.

We reviewed three comprehensive and well organised personnel files. Appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. We saw evidence that fire drills were undertaken periodically, the most recent being March 2017.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. (Legionella is a bacterium which can contaminate water systems in buildings.)
- There were arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. Staff worked flexibly to cover any changes in demand, such as annual leave, sickness or seasonal pressures.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.
- There were anaphylaxis kits in consulting and treatment rooms.
- A first aid kit and accident book was available.
- Staff received annual basic life support training.
- The practice had a defibrillator and oxygen, with both adult and children's masks available. We were informed there was a verbal arrangement in place with the other GP practice in the building, where they could use this equipment if needed. However, on the day of the inspection an incident occurred which resulted in the practice revising their arrangements. It was then agreed that the emergency equipment would be for the use of City View Medical Practice only and to be kept on site.
- We saw that some emergency medicines were stored in an unlocked drawer, within a trolley, in an area that was accessible to patients. There had been no risk assessment as to what emergency medicines were to be kept in the practice. During the inspection this trolley was moved to a locked room and staff were advised of its new location.
- Within two working days after the inspection we were shown evidence of the revised systems and processes the practice had put in place regarding emergency medicines and equipment. A risk assessment of what emergency medicines were to be kept in the practice was also submitted to CQC as evidence.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- Clinicians rotated every three months to be responsible for reviewing local and national updates, including NICE guidelines, and feedback to staff.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results from 2015/16 showed the practice had achieved 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. Data from this period was applicable to the previous provider and showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example, the percentage of patients on the diabetes register, whose blood pressure reading in the preceding 12 months measured 140/80 mmHg or less, was 78% compared to the CCG and national averages of 77%.
- Performance for mental health related indicators was higher than CCG and national averages. For example, 100% of patients who were on medication (lithium) had undergone appropriate blood tests in the preceding 9 months, compared to the CCG and national averages of 97%.
- Performance for chronic obstructive pulmonary disease indicators was higher than CCG and national averages. For example, 93% of patients had undergone a review of their care in the preceding 12 months, compared to the CCG and national averages of 89%.

QOF data for the period 2016/17 had not yet been published and, again, related to the previous provider. The practice was currently undertaking work relating to 2017/18 QOF. There was an identified clinical lead for QOF who undertook weekly searches to monitor how they were performing.

The practice participated in peer reviews, allowing them to benchmark against other local GP practices.

Clinical audits, including medicine audits, and reviews were undertaken, to ensure patients were received appropriate treatment in line with clinical guidance. We saw evidence where quality improvement was discussed at clinical and practice meetings. There was a programme of audit which the practice pharmacist was undertaking regarding medicines management.

We reviewed two clinical audits:

- A minor surgery audit showed that histology had been sent for all excisions and received back in the appropriate timescales, consent had been gained and diagnosis had been correct.
- An audit regarding antibiotic prescribing showed that in some instances the length of treatment prescribed was longer (seven days as opposed to five days). Actions and learning were identified and shared with other clinicians. A repeat audit showed improvements had been made.

Effective staffing

The practice had worked hard at recruiting an appropriately skilled workforce, to support delivery of care services for their patients. Due to a reduction in the number of GPs, they had undergone a review of staffing to identify what skills were needed to deliver care services for their patient population. As a result, they had employed ANPs, a mental health specialist nurse and a practice pharmacist.

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Practice nurse and healthcare assistant training programmes had been developed by an ANP. These were comprehensive and included competency 'sign offs'.
- Staff received mandatory training, such as safeguarding, fire safety awareness and basic life support. Staff had access to and made use of e-learning training modules and in-house training. The practice could demonstrate how they ensured staff received role-specific training and updates. The practice had protected learning time one afternoon a month. This was used to support the training and development of staff, in addition to other training programmes
- 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. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. Staff had received an appraisal within the last 12 months.
- Independent nurse prescribers received weekly clinical supervision from a GP and had access to other avenues of support.
- The practice had developed an apprenticeship programme for trainee administration staff. The apprentices were supported through a training pathway to equip them with the skills and experience to apply for a practice administration post.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results.

Although the avoiding unplanned admissions enhanced service, originally aimed at 2% of a practice population, had ceased to be funded, the practice had continued with the service. They had identified benefits to patients and, consequently, extended it to all patients who were at a high risk of an unplanned hospital admission, particularly those frail elderly patients. Care plans and reviews were undertaken for all identified patients.

Staff worked with other health and social care professionals, including local neighbourhood team workers and a consultant for elderly care. By working collaboratively they could meet the range and complexity of patients' needs and plan ongoing care and treatment. With the patient's consent, the practice used shared care records. The practice had been an early adopter of this way of sharing information between health services and professionals.

We saw evidence of regular meetings both in-house and with other health care professionals, such as health visitors and palliative care nurses, to support co-ordination of patient care; including end of life care. Staff had access to the GPs, outside of these meetings, to discuss any concerns regarding patients.

The practice had some patients who resided at two local care homes. Clinicians undertook weekly 'ward rounds' to review care and treatment plans. They also liaised with care home staff to support them in delivery of person-centred care to those patients.

The practice worked with the local community learning disabilities team to increase access to and the uptake of health reviews by patients.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services effective?

(for example, treatment is effective)

- Those patients who were non-English speaking had access to interpreters and translated information to support them in consent to care.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice was participating in a Leeds project, looking at patients who were at risk of frailty. At the time of our inspection they had identified 92 patients, using the frailty index; ranging from moderate to severely frail. An assessment of each patient was undertaken, which included what goals the patient wanted to achieve, such as being able to walk to the practice. A multidisciplinary approach was used, which included input from physiotherapy and occupational therapy. At the time of our inspection the project had not been in place long enough to evidence out outcomes.

Since May 2017, the practice had also participated in the falls prevention scheme; as part of the CCG quality improvement programme. The practice had identified 120 patients who were eligible. Again, by collaboratively working with other health professionals, these patients were supported to prevent a fall. An assessment and medication review were undertaken, and a care plan developed by the ANP in conjunction with the patient. Again, it was too early to measure any outcomes.

The practice had a group of volunteer health champions (who were patients and members of the patient participation group). They provided a variety of support for patients, which included carers' events, coffee mornings and healthy lifestyle information. They also facilitated a healthy walk group for patients to participate in as they wished.

We were informed of the training the champions had recently received on bowel cancer screening. In conjunction with practice staff, they intended to have a promotional event to encourage patients to take up the screening. The practice routinely invited approximately 200 eligible patients per quarter, proactively encouraged attenders and followed up those patients who did not attend (DNA) their appointment. It was acknowledged that despite all the positive interventions, at 47% the uptake rate for bowel screening was lower than the CCG average of 57% and the national average of 58%.

We also spoke with a health improvement practitioner (HIP) from the local public health department, regarding bowel screening in the practice. They informed us of the "gold standard service" which was offered by the practice. City View Medical Practice had a 'whole practice' approach and was cited as being a good example of best practice. The model was promoted to other practices within the CCG. We were informed by the HIP that the practice had high levels of deprivation, poor literacy and a multi-cultural patient population, which contributed to the lower uptake rates overall.

Other cancer screening programmes were proactively promoted and non-attenders contacted. The uptake for cervical screening was 64% (CCG 74%, national 73%) and the uptake for breast screening was 58% (CCG 67%, national 72%)

As a result of a review regarding the benefits of gardening on the health and well-being of people, the practice had rented an allotment. This was overseen by the patient participation group and the health champions. Any patients could work on the allotment. All the produce, such as fruit, vegetables and flowers, were available to patients for a small donation. At the time of our inspection, we saw displays of the produce and patients making 'purchases'. Patients commented positively about the allotment. We also saw evidence of an article in a local journal, citing the practice and the health benefits of the allotment.

The practice also provided information and advice relating to smoking cessation, weight loss, activity, healthy eating and counselling. A local drug and alcohol service held a weekly clinic at the practice, where patients with substance misuse issues could access help, advice and support.

Childhood immunisations were offered in line with the public health programme. Uptake rates for all children aged eight weeks to 5 years were, on average 96% (CCG 93%, national 91%).

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

The practice had a patient-centred culture and we observed that members of staff were courteous and treated patients with kindness, dignity, respect and compassion. Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We observed that:

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Patients had access to male or female clinicians.

On the day of inspection patients told us they received good care and service and found the reception staff to be friendly and helpful. They said staff treated them with dignity and respect.

We also spoke with three members of the patient participation group (PPG). They told us they felt the practice engaged with them and felt they were treated with dignity and respect. We were also informed of the challenging times the practice had undergone, especially with regard to a reduction in clinicians and the recent takeover of the new provider.

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

- 75% of patients said the last GP they saw or spoke to was good at listening to them; compared to the CCG and national averages of 89%.
- 72% of patients said the last GP they saw or spoke to was good at giving them enough time (CCG 86%, national 86%).
- 70% of patients said the last GP they spoke to was good at treating them with care and concern (CCG 86%, national 86%).
- 81% of patients said they had confidence and trust in the last GP they saw or spoke to (CCG and national 95%).
- 91% of patients said the last nurse they saw or spoke to was good at listening to them (CCG and national 91%).
- 87% of patients said the last nurse they saw or spoke to was good at giving them enough time (CCG 93%, national 92%).
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern (CCG 90%, national 91%).
- 94% of patients said they had confidence and trust in the last nurse they saw or spoke to (CCG 97%, national 97%).

These results applied to the previous provider and had occurred during a period of challenges in staffing. The current provider had recently undertaken a patient survey and could evidence some improvement. For example, 93% of patients said they found staff to be friendly and approachable; 83% of patients said they would recommend the practice to friends and family.

We were informed by the practice that they were hoping to improve patient satisfaction regarding clinicians. As they had increased the numbers of clinicians available, they were now able to provide a stable workforce to support continuity of care.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed patients responses were mixed in relation to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 66% of patients said the last GP they saw was good at explaining tests and treatments; compared to the CCG average of 87% and the national average of 86%.
- 68% of patients said the last GP they saw was good at involving them in decisions about their care (CCG 83%, national 82%).
- 89% of patients said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG 89%, national 90%).
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care (CCG 86%, national 85%).

Good

Are services caring?

However, the above results applied to the previous provider and did not reflect the information recorded on the CQC comment cards or what patients told us on the day of inspection. 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.

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

- We saw that double appointments were provided for those patients who were non-English speaking. The practice co-ordinated translation services for those appointments. This supported those patients to be involved in their care and treatment decisions. Patients were also told about multi-lingual staff that might be able to support them.
- Information leaflets were available in easy read format and in some languages befitting the patient population.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Leaflets and notices were available in the patient waiting area which informed patients on how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice held a carers' register and had identified 168 patients as carers, which equated to approximately 2% of the practice list. The practice informed us they were working at identifying any carers not already on the register. Each carer was given a carers' pack, which contained a variety of information how to access additional support and benefits. Health checks and influenza vaccinations were offered to those patients They had good links with Carers Leeds and signposted patients accordingly.

With the support of the practice health champions, regular events were held for carers. For example, an Easter event and a "strawberries and cream scones" event. These were promoted by writing to all carers and inviting them to attend. We saw evidence of good attendance at these events and the monthly carers' support group.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- Extended hours were available on Wednesdays and Thursdays.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- The practice sent text message reminders of appointments and test results.
- A triage system was in place to support patients being seen by the appropriate clinician.
- There were longer appointments available for patients with a learning disability, complex health need or required interpretation services.
- Longer appointments were available with the mental health specialist nurse.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Patients were able to receive travel vaccines available on the NHS.
- There were accessible facilities, which included a hearing loop, translation and interpretation services available. Some staff could speak languages appropriate to the patient population.
- A letter was sent to children just before their 16th birthday. This contained advice on how to access the practice services, such as booking appointments online and receiving text reminders. It also assured patients of confidentiality.
- A separate, private, room was available for mothers who wished to breastfeed.
- In response to patient feedback, the practice had provided activities, such as colouring books and pencils, in the waiting room.
- Weekly 'ward rounds' were undertaken at two local care homes where the practice had patients who resided there.

The practice had identified they had a higher number of patients who had a mental health condition (31%, compared to CCG and national average of 11%). As a result, in January 2017, the practice employed a mental health specialist nurse, who provided additional support for identified patients. They undertook health checks, offered targeted interventions and provided coping strategies. The nurse liaised with community mental health services and local drug and alcohol workers, to review care plans and support patients who had mental health and substance misuse issues. The nurse also referred appropriate patients to connect for health, who could also provide additional support.

This model of working was in the process of being shared with other practices within the Leeds South and East Clinical Commissioning Group. At the time of our inspection, there was only anecdotal data regarding improved outcomes. For example, fewer acute hospital admissions and stability in the mental health and well-being of some patients.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday. Extended hours were available on Wednesdays from 7am to 6.30pm and Thursdays from 7am to 7.30pm.

Appointments were offered at the following times:

Monday: 8.10am to 12.30 pm and 1pm to 5.40pm

Tuesday: 8.10am to 12.30 pm and 1pm to 5.40pm

Wednesday: 7.10am to 6.30pm

Thursday: 7.10am to 7.10pm

Friday: 8.10am to 12.30 pm and 1.30pm to 5.50pm

In addition to pre-bookable appointments, urgent appointments were also available for patients that needed them.

In response to demand and clinical capacity, a triage system had been introduced. This ensured that patients needing to be seen on the same day as requested were directed to the appropriate clinician, such as a GP, ANP or practice nurse, depending on their individual need.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Results from the national GP patient survey (which related to the previous provider) showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages.

- 83% of patients were very or fairly satisfied with the practice opening hours; compared to the CCG average of 77% and the national average of 76%.
- 45% of patients said they could get through easily to the practice by telephone (CCG 66%, national 71%).
- 73% of patients said they were able to get an appointment to see or speak to someone the last time tried (CCG 82%, national 84%).
- 77% of patients said the last appointment they got was convenient (CCG 79%, national 81%).
- 62% of patients described their experience of making an appointment as good (CCG 74%, national 73%).
- 33% of patients said they don't normally have to wait too long to be seen (CCG 60%, national 58%).

Regarding access, out of 18 patients we spoke with, three said they had found it difficult getting through to the practice by telephone. The remaining patients said it could vary, but were generally satisfied. Only one of the CQC comment cards made reference to access.

As a result of low patient satisfaction rates, the practice had extended the hours for telephoning for a same day appointment to between 8am and 12 midday. However, when speaking to patients we found that most rang at 8am; some of whom stated they had difficulty getting through at that time. All but three of the patients we spoke with, were aware of the telephone access to same day appointments and were satisfied with the triage system.

The practice had a system to assess:

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

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

Listening and learning from concerns and complaints

The practice had a system 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 looked at 39 complaints received in the last 12 months. The practice recorded all formal complaints and verbal "grumbles". Some related to the triage system when it was in the early stages of development, and six related to locum GPs. The practice had addressed the issues relating to the locum GPs and had reduced their need to use them, due to the increased number of directly employed clinicians.

There was a dedicated staff member of the management team who dealt with complaints. We reviewed a sample of complaints and saw that they had been dealt with in a timely way, with openness and transparency. Where applicable, lessons had been learned and shared with staff. We saw evidence of this from meeting minutes.

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 recently undergone a significant period of change, which included a new provider. At the time of our inspection the practice had a strong vision, which included working with patients to support the delivery of high quality care and promote positive outcomes for patients. The values promoted by the practice included being open and accountable, working in partnership, being professional, caring and respectful. All staff were aware of the vision and values.

The practice had a clear strategy and supporting business plans which were regularly monitored and reflected the vision and values.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There were reviews and analysis of patient feedback, performance outcomes and significant events.
- A comprehensive understanding of the performance of the practice was maintained. A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Communication channels and meetings had been streamlined to improve effectiveness and efficiency. A structure of internal meetings was embedded, to ensure information and learning was disseminated and feedback gathered proactively.
- Each day, before the practice opened, there was a 'daily huddle' for any staff in the practice. This ensured everyone knew what staff were available, duty doctor, messages, priorities and any meetings that day. Notes were written on a whiteboard in the reception office so all staff had access to the information, including those who had been unable to attend the 'huddle'.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- There was a strong focus on continuous learning and development at all levels. The practice had revised their induction programmes. Staff participated in annual performance reviews and attended staff meetings.

Leadership and culture

On the day of inspection, the provider and the practice clinical leads and managers could demonstrate they had the experience, capacity and ability to run the practice and ensure high quality care was delivered to patients.

The practice had strong and visible clinical and managerial leadership. Staff were aware of how the provider and the practice worked together, and their individual roles and responsibilities.

- There was evidence of good teamwork and high standards were promoted and owned by all the staff.
- The practice held a range of multidisciplinary meetings,including meetings with community matrons and social workers, to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and discuss safeguarding concerns. We saw formal minutes from these meetings.
- We saw evidence of regular team meetings being held within the practice.
- Staff said they felt respected, valued and supported and were encouraged to identify opportunities to improve the service delivered by the practice.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. This included support training for all staff on communicating with patients about notifiable safety incidents.

A culture of openness and honesty was promoted. From the sample of documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

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

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

The practice encouraged and valued feedback from patients and staff.

Are services well-led?

Good

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

- The practice undertook patient surveys and used the Friends and Family Test, to evaluate how well they were doing regarding patient satisfaction.
- They monitored complaints and compliments and identified any themes.
- The patient participation group (PPG) was very active and supported practice development. We were informed how they were actively trying to promote the PPG to younger patients. There was information in the practice alerting patients to the PPG.
- 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 to improve how the practice was run.

Continuous improvement

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

- The practice recognised future challenges and was proactively succession planning their workforce in order to maintain the service to meet evolving patient care needs. They were an active member of the South East Leeds Group Practice Federation. The practice manager was joint lead on workforce planning work streams.
- They intended to mentor student nurses from September 2017, as they recognised the importance of the need to develop practice nurses.
- The practice provided an apprenticeship programme to develop reception staff.
- They shared their experiences and new ways of working with other practices that were experiencing recruitment difficulties.
- The model of care delivered by the practice, in conjunction with the provider, was being evaluated with a possibility of it being seen as a 'beacon practice'.