Lingwell Croft Surgery

Inspection report

16 Shelldrake Drive
Middleton
Leeds
West Yorkshire
LS10 3NB
Tel: 0113 270 4848
www.lingwellcroft.co.uk

Date of inspection visit:
Date of publication: 17/01/2019

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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. The practice was previously inspected in October 2014 and received a rating of Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Lingwell Croft Surgery on 13 November 2018 as part of our inspection programme.

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

- There was a comprehensive system in place to ensure the safe management of high risk medicines.
- Systems for managing staff training and induction were effective.
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The Patient Participation Group (PPG) engaged with patients and actively supported membership to include people from all backgrounds.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- In addition to urgent daily appointments, the practice kept appointments free for patients who may be referred to their GP by NHS 111. The practice enabled NHS 111 services to directly book into the practices appointment system.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC inspector**.** The team included a GP specialist adviser.

Background to Lingwell Croft Surgery

Lingwell Croft Surgery is registered with CQC to provide primary care services. The regulated activities that they are registered to provide are family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures.

These regulated activities are provided from the following address: 16 Shelldrake Drive, Middleton, Leeds, West Yorkshire, LS10 3NB.

Tel: 0113 270 4848

Website:

The practice is open 8:30am to 8:00pm on Monday and Tuesday, 8:30am to 6.00pm on Wednesday to Friday; and closed on a weekend. Patients can book appointments in person, via the phone and online.

When the practice is closed patients access the out of hours NHS 111 service.

The practice is part of NHS Leeds CCG. It is responsible for providing primary care services to 14,897 patients. The female patient population of the practice made up 51% of the practice population, 49% are males and 17% of all patients are over 60 years of age.

The practice is meeting the needs of an increasingly elderly patient list size.

This practice is well-established and has 10 GPs, six of whom are partners. There are six male and four female GPs.

Urgent appointments are available each day and GPs also provide telephone consultations for patients. An out of hours service is provided for patients by a federation when the practice is closed. Information about the out of hours service is provided to patients on the practice website and the practice phone system. Patients can book out of hours appointments via the practice.

When we returned to the practice for this inspection, we checked, and saw that the previously awarded ratings were displayed, as required, in the practice premises. The overall rating was displayed on the practice website with a link to the inspection report.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. We saw evidence that all staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. All staff 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.
- We saw evidence that alerts on the clinical system were used to notify staff of vulnerable patients.
- We found that there was a clear audit trail for all significant events including the sharing of learning and outcomes. For example, we reviewed minutes from clinical meetings and practice meetings where learning from significant events was shared.
- Staff we spoke with on the day of inspection were able to demonstrate they were aware of recent significant events and the outcomes.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- The practice had arrangements in place to ensure that facilities and equipment were safe and in good working order.
- We reviewed arrangements for managing waste and clinical specimens and found that these systems kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was a comprehensive induction system for all new staff; tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Non-clinical staff were able to identify 'red flag' symptoms for sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

There was a process for monitoring uncollected prescriptions and the practice had reliable systems for appropriate and safe handling of medicines:

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Blank prescription pads were securely stored and there was a system in place to monitor their use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.

Good

Are services safe?

- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, we reviewed minutes from clinical meetings and practice meetings where learning from significant events was discussed.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based guidance. We found that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. For example, we reviewed clinical audits which took into account the most recent NICE guidance.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice worked collaboratively with a psycho-geriatrician (specialising in the assessment and treatment of elderly people) to support this population group.
- The practice employed a specialist advanced nurse practitioner (ANP) who attended to all of the 87 registered patients in care homes; providing essential liaison between patients, their families, staff and external agencies. This had led to a reduction in home visit requests from care homes from an average of 65 GP visits per month to an average of 15 per month.
- All residents were considered for future care planning considering their end of life wishes.
- The ANP also reviewed housebound patients in their own homes as required, ensuring regular medication and dementia reviews were carried out.

People with long-term conditions:

- Performance for patients with diabetes and hypertension showed improvement. (Please refer to the evidence table for details on the improvement).
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- 'Admission avoidance' care plans were used for patients at risk of recurrent hospital admissions.
- Text reminders for health checks were sent to patients; the practice actively followed up non-responders with letters and phone calls.

Families, children and young people:

- Childhood immunisation uptake rates were higher than the target percentage of 90%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- There was a comprehensive alert system in place for vulnerable children.
- The provider opened late until 8pm on Mondays and Tuesdays offering GP and nurse appointments to accommodate school children and young people with working parents.
- There were late and weekend GP appointments available at a nearby urgent care centre which was within easy walking distance.
- The provider offered ante-natal clinics which were run daily by the midwife.
- New mothers were contacted after delivery for an eight-week check-up appointment with a GP prior to receiving immunisations from a practice nurse.

Working age people (including those recently retired and students):

Good

Are services effective?

- The practice's uptake for cervical screening was 80%, which was in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- There was online access for appointment booking and repeat prescription requests.
- The provider offered appointments outside of core hours seven days a week from the surgery and from the nearby urgent treatment centre.
- The provider offered online access for appointments, prescriptions, results and access to medical records (27% of registered patients had online access).
- The provider offered telephone consultations.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice currently held a register of patients with a history of substance misuse (569) and children at risk of harm or abuse (212).
- The practice worked collaboratively with a local drug and alcohol service to manage patients with addiction problems, including a fortnightly clinic with drug and alcohol counsellors, was hosted by the practice.
- Longer appointments were offered to vulnerable patients.
- The provider was a hub for 'Forward Leeds' being only one of two practices in Leeds offering a service to patients with alcohol and substance misuse problems.
- Patients with learning difficulties were seen by specially trained GPs for an annual review.
- The provider employed a safeguarding lead who attended external bi-monthly safeguarding peer review meetings and discussed safeguarding at monthly in-house clinical meetings.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The practice commissioned a mental health service in partnership with 10 other practices in the locality. The practice had successfully gained funding for the scheme for two years which had since been extended.
- The provider hosted a mental health worker three days a week.
- The practice employed an ANP (Advanced Nurse Practitioner) specialising in elderly care for patients living with dementia in the three local care homes.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- Quality and outcomes framework (QOF) results were comparable to or above the local and national averages.
- The practice was actively involved in quality improvement activity and had a programme of clinical audits in place to monitor the quality of care. We found that care had been improved as a result of clinical audit.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Good

Are services effective?

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- We saw certificates which confirmed staff whose role included immunisation and taking samples for the cervical screening programme had received specific training. Staff could demonstrate how they stayed up to date with revalidation and continual professional development.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation. There was an induction programme for new staff.
- There was a clear approach for supporting and managing internal staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records which showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. For example, we reviewed minutes from multi-disciplinary meetings and found that care pathways for vulnerable patients and patients with complex needs were discussed.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for patients in their home or care homes. The practice conducted one session per week offering proactive visits to all 87 registered patients in three care homes in the area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans which were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- In addition to urgent daily appointments, the practice kept appointments free for patients who may be referred to their GP by NHS 111. The practice enabled NHS 111 services to directly book into the practices appointment system.
- The practice offered one to one training for any patient who wanted to learn how to use the practice online system. Patients could bring their laptops and smartphones into the practice and the staff would help set up access to the surgery's online systems.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were mostly below the local and national averages for questions relating to kindness, respect and compassion.
- The practice had completed their own patient satisfaction survey and the results indicated nearly all patients would recommend the practice to their friends or family.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers could access and understand the information that they were given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practice's GP patient survey results were below the local and national averages for questions relating to involvement in decisions about care and treatment.
- The national patient survey received a total of 106 surveys back from patients; the practices own feedback was from 98 patients.
- The practice felt that they treated patients with care and concern and had always scored highly in this area in previous surveys. They were surprised at the figures from the national survey but remained confident that they were providing a very caring service in view of their own survey results.
- The practice had been aware that there was a need for additional mental health support for patients and as such commissioned a local mental health service offering assessment and treatment in the locality, to operate from the practice three days a week.
- The practice was concerned by the low percentage who said they had enough support as they were constantly referring patients with long term conditions to voluntary and community organisations. The feedback from the local organisations was that they were the highest referrers in the area.
- The nursing team dealt with patients with long term conditions and they informed patients of the various local services available to help manage their conditions as part of the Collaborative care and support planning (CCSP) that the practice participated in as part of the CCG Quality Improvement Scheme. We saw posters in the surgery and consulting rooms, and leaflets to hand out to patients.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed, reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Longer appointments were provided when required for this population group.
- The practice was the first in Leeds South & East locality to set up and run a shared clinical service offering phlebotomy and blood pressure monitoring to care and residential home and housebound patients. It was felt that this cohort of patients were not getting the same level of service as non-housebound patients and the aim was to further develop frailty and dementia tests that the phlebotomists could carry out.
- The scheme covered a population of 80,000 patients employing two phlebotomists and was launched in May 2015 with CCG funding, that the practice applied for. The service was successful and it was rolled out to all 43 practices in the Leeds South & East area. The management of this passed from Lingwell Croft Surgery to the 'SELGP' federation from April 2017. The shared phlebotomy service had led to increased collaborative working and shared services amongst practices in Leeds South & East.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice worked closely with the local district nursing team, social workers and palliative care nurses to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- 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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- In addition to urgent daily appointments, the practice kept appointments free for patients who may be referred to their GP by NHS 111. The practice enabled NHS 111 services to directly book into the practices appointment system.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

People experiencing poor mental health (including people with dementia):

Good

Are services responsive to people's needs?

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Staff understood their responsibilities in relation to the mental capacity act.
- In-house counselling services were available delivered by local mental health services.

Timely access to care and treatment

- The practice fulfilled their contractual obligations and provided above the expected number of appointments.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients we spoke with on the day reported that the appointment system was easy to use.
- The practice's GP patient survey results were below local and national averages for questions relating to access to care and treatment.
- The practice recently identified that there was an issue regarding patient access to the National Diabetes Prevention Programme (NDPP); they had now invited the NDPP to run weekly clinics from the surgery to ensure a higher attendance. Previously the NDPP clinics were only held Monday to Friday between 9.00am and 5.00pm and at quite a distance from Middleton. From next month the NDPP planned to run late night clinics once a week until 7.00pm from the practice.
- 'One You' who were an organisation who provided smoking cessation support and weight management also had a weekly clinic run from the practice which was well attended.
- The practice has recently organised in-house Diabetes group meetings attended by Diabetes UK, with other local services attending informing patients how they could be accessed.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice produced a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The practice manager told us that they believed that the health and wellbeing of their patients was their first consideration.
- Their belief was that staff should deal with patients, their families and each other in a friendly way with courtesy, professionalism, integrity and respect.
- The vision of Lingwell Croft Surgery aimed to be a high performing organisation, which was both caring and effective; working to provide the highest possible quality of services to patients and their families, within a happy working environment.

Culture

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- There was a comprehensive suite of practice specific policies available to all staff. We reviewed these policies.
- There was a clear audit trail showing that learning outcomes from patient safety alerts, significant events and complaints were shared. For example, we reviewed two sets of recent meetings which recorded discussions around the learning and outcomes of patient safety alerts and significant events.
- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.

Good

Are services well-led?

- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on the quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance, this can be evidenced by the improved outcomes for patients with diabetes and hypertension. Please refer to the evidence table for more detail on these improvements.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. For example, improving outcomes for patients with diabetes and hypertension;
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group, members told us that clinical partners at the practice were always in attendance for patient participation group meetings.
- Patients were encouraged to leave feedback on their experience within the practice.
- The practice had an annual business planning meeting involving all of the staff; this year an away day was planned at a local hotel to develop the practice strategy for the future. All 44 staff attended this event in March 2018.
- The practice manager and assistant practice manager attended training in 2018 on how to engage with patients to make engagement with patients more effective.

Continuous improvement and innovation

There were of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- We saw evidence that newly implemented systems were evaluated and improved. For example, the staff training programme.
- Partners recruited a Business Manager to help improve governance arrangements.
- The practice had a GP partner on the board of Directors of the 'SELGP' federation, and the practice manager attended board meetings representing all practice managers in Leeds South & East federation. The practice also had a salaried GP and a practice nurse who were CCG locality leads representing 105,000 patients from 14 practices.
- The practice accommodated weekly citizens advice bureau clinics for its patients provided by professional welfare benefit advisers. Patients are referred by GPs and ANPs (Advanced Nurse Practitioner) and they could also self-refer.
- A practice nurse organised various health based activities to encourage patient's general health, exercise and social interaction. A local walking group was run every Tuesday at 12 noon in Middleton Park.
- A practice nurse had set up a Leeds wide respiratory network and provides specialist respiratory training to nurses at other practices. The nurse also volunteered at local 'Breathe Easy' groups for smoking cessation.

Good

Are services well-led?

- The practice had invested in COPD (Chronic Obstructive Pulmonary Disease) training and was a respiratory centre of excellence as COPD nurses and all Health care assistants are ARTP (Association for Respiratory Technology & Physiology) spirometry trained.
- The practice hosted a midwife who works for Leeds Community Health based at the surgery five days a week as there was a high population of pregnant patients.
- The visiting midwife won the Leeds Teaching Hospital (LTHT) Midwife of the year 2018.