Leeds City Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Leeds City Medical Practice on 30 October 2014 and 3 November 2014. Overall the practice is rated as good.

The inspection team found the practice was safe, effective, caring, responsive and well led. It was also rated as good for providing services for all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- There were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

However, there were areas of practice where the provider should make improvements:

- The practice used nurses and health care professionals to act as a chaperone when required. However during busy periods members of the reception team were asked to provide this service. Some members of the reception team had not received appropriate chaperone training.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. There were standard operating procedures and local procedures in place to ensure any risks to patient's health and wellbeing were minimised and managed appropriately. The practice learned from incidents and took action to prevent recurrence. Medicines were stored and managed safely. The practice buildings were clean and well maintained and systems were in place to oversee the safety of the buildings.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' received care and treatment in line with recognised best practice guidelines. Their needs were consistently met and referrals to secondary care were made in a timely manner. The practice worked collaboratively with other agencies to improve the service for people.

Are services caring?

Good

The practice is rated as good for providing caring services. The patients who responded to Care Quality Commission (CQC) comment cards and those we spoke with during our inspection, gave positive feedback about care and treatment they received at the practice. Patients described to us how they were included in all care and treatment decisions and they were very complimentary about the care and support they received. There were some negative comments received regarding the change in the appointment system.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for providing well-led services. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

The practice was meeting people's needs in providing a service where the GPs and nurses had specific lead responsibility for areas of care, for example, safeguarding adults and children.

There were systems in place to monitor and improve quality and identify risk.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and were performing well against national targets. For example, a good uptake on the percentage of patients aged 65 and over who had received their flu vaccination. It was responsive to the needs of older people, and offered home visits for very elderly and housebound patients.

People with long term conditions

Good

The practice is rated as good for people with long-term conditions. There were systems in place to ensure patients with multiple conditions received one annual recall appointment wherever possible. This helped to offer the patient a better overall experience in meeting their needs. Healthcare professionals were skilled in specialist areas and the practice used templates to ensure consistent care, coding on the clinical system and annual review dates were set to ensure ongoing management of treatment.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided family planning clinics, baby checks and childhood immunisations and there were in house midwife sessions held weekly at the practice. The GPs we spoke with told us that requests for appointments for children were always triaged by telephone and children would always be seen on the same day should this be needed.

Working age people (including those recently retired and students)

Good

The practice is rated as good. The practice had extended hours to facilitate attendance for patients who could not attend appointments during normal surgery hours. Patients were able to book appointments and order prescriptions online, which made it easier for those patients who found it difficult to contact the practice during working hours. NHS Health checks were offered to all patients between the ages of 40 and 75 years old.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances make them vulnerable. The practice had arrangements in place for longer

Summary of findings

appointments to be made available where patients required this and access to translation services when needed. A mental health and alcohol therapist attended the practice weekly and the practice hosted a citizens advice clinic at two of their sites on a weekly basis.	
People experiencing poor mental health (including people with dementia) The practice is rated as good for people experiencing poor mental health (including people with dementia) The practice has access to professional support such as the local mental health team and psychiatric support as appropriate. The practice were proactive in carrying out dementia screening in those patients identified as high risk.	Good 

Summary of findings

What people who use the service say

We received 23 completed CQC patient comments cards where patients and the public shared their views and experiences of the service. We also spoke with nine patients on the day of our inspection and this included a member of the Patient Reference Group (PRG).

The patients who had completed the CQC comments cards and those spoken with were complimentary about the level of care and treatment they had received. However, there were some negative comments about the change to the appointment system and poor communication at the Parkside surgery branch.

Most of the patients we spoke with told us they were always treated with dignity and respect. They felt all the staff at the practice took time to listen to them and involved them in decisions about their care. However, one person told us they did not always feel listened to.

Areas for improvement

Action the service SHOULD take to improve

The practice used nurses and health care professionals to act as a chaperone when required. However during busy periods members of the reception team were asked to provide this service. Some members of the reception team had not received appropriate chaperone training.

Leeds City Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, two GPs, a practice manager and an expert by experience.

Background to Leeds City Medical Practice

Leeds City Medical Practice operates from three sites within the Beeston area of Leeds. The practice serves a population of approximately 15,000 patients who can access services at any of the three sites.

The practice has eight general practitioner (GP) partners (five male and three female). Working alongside the GPs are three practice nurses, a treatment room nurse, a nurse manager and two health care assistants. There is an experienced management team including, a practice manager, assistant manager and office manager who are supported by 18 receptionists and three secretaries.

The practice is a training practice and accommodates GP Registrars and medical students. GP Registrars are fully qualified doctors who are completing their specialist training to become a GP.

The practice has a General Medical Services (GMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

Leeds City Medical Practice and Parkside Surgery offer a range of appointments between 8.00am and 6.00pm Monday to Friday. With extended hours being provided between the hours of 6.30-8.30pm on Monday evenings at Leeds City Medical Practice and between 7.30-8.00am on Thursday mornings at Parkside Surgery.

Crossland Surgery opening hours are: Monday from 12.00pm-6.00pm, Tuesday-Thursday from 9.00am-12.00pm and Friday from 9.00am-12.00pm.

The practice is closed from 12.00pm on the second Tuesday of every month and this is for training purposes.

When the practice is closed, out of hours cover for emergencies is provided by the NHS 111 service.

The practice offer a range of specialist clinics/services and these include: family planning, baby clinic and child health, antenatal clinic, diabetes clinic and minor surgery.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to CQC at that time.

Detailed findings

How we carried out this inspection

Before visiting the practice, we reviewed information we hold about the service and asked other organisations to share what they knew about the service. We asked the surgery to provide a range of policies and procedures and other relevant information before the inspection.

We carried out an announced inspection visit on 30 October and 3 November 2014. This was because the provider operated from three branches and it was not possible to visit the three branches in one day. During the inspection we spoke with staff including GPs, practice manager, practice nurses and reception staff.

We spoke with nine patients who used the service and this included a member of the patient reference group (PRG). We also reviewed CQC comments cards where patients and members of the public shared their views and experiences of the service.

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

Information from the Clinical Commissioning Group (CCG) indicated the practice had a good track record for maintaining patient safety. Staff we spoke with were clear and understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice used a web based reporting system which enabled them to be reviewed by the Clinical Commissioning Group (CCG). We were able to review a summary of incidents that had been identified by the practice over the last five months and saw that these outlined the action taken and lessons learned.

We saw evidence findings from incidents were shared with relevant staff. Staff, including receptionists, and nursing staff, knew how to raise an issue for consideration at meetings and they felt encouraged to do so.

Safety alerts were reviewed by the assistant practice manager. They were then emailed to relevant staff and discussed with the nurse manager regarding the most appropriate action to take. Following review of the alerts, the decision was made as to whether they would be discussed at the next practice meeting.

Reliable safety systems and processes including safeguarding

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

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

Patients had access to a chaperone when attending the practice for an appointment. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. The nurses and health care assistants acted as chaperones and were appropriately trained. Reception staff would act as a chaperone if nursing staff were not available. However, some members of the reception team had not received appropriate training.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for staff to follow regarding storage and handling of medication, which described the action to take in the event of a potential cold chain failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

Are services safe?

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control and all staff had received infection control training.

An infection control audit had taken place by Leeds Community Healthcare Infection Control Team in 2013. This identified issues around waste management and monitoring cleaning standards. A repeat audit had taken place in March 2014 and the practice had received confirmation that all actions had been addressed.

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

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We saw documentation to confirm a Legionella assessment had been undertaken in March 2014 and all risks had been identified and actioned upon.

Equipment

We saw equipment was available to meet the needs of the practice and this included; a defibrillator and oxygen, which were readily available for use in a medical emergency. Routine checks had been carried out to ensure they were in working order.

We saw that equipment had up to date annual, Portable Appliance Tests (PAT) completed and systems were in place for routine servicing and calibration of medication equipment where required. The sample of portable electrical equipment we inspected had been tested and was in date.

Staffing and recruitment

The practice had a recruitment policy which had been reviewed in March 2014. This set out what pre-employment checks would be carried out; for example Disclosure and Barring Service (DBS) checks.

We looked at the recruitment files for one practice nurse and one receptionist and saw these contained all relevant documentation. For example; contract of employment, evidence of registration with professional body, references and induction checklist. All practice staff had been DBS checked and we saw a summary of this information stored separately.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We were able to review minutes of staff meetings where staffing and work levels had been discussed.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the buildings, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

The practice had clear lines of accountability for patient care and treatment. Each patient over the age of 75 had a named GP. The GPs and nurses also had lead roles such as safeguarding, diabetes and asthma.

The practice told us how they had responded to an increase in list size following the takeover of a private practice. This included closing a smaller branch site in the

Are services safe?

North of Leeds and increasing the number of GPs at the practice. The new GPs employed by the practice had all been given partnership to ensure a greater level of commitment to the population the practice served.

We spoke with the practice manager who told us each practice site, had a minimum number of staff required in order to operate. In order to ensure adequate cover at all times, staff were able to work from any of the three sites. Annual leave and sickness was covered by part time staff who were able to work extra hours. We spoke with three receptionists who told us they were happy with the hours they worked.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed and who to contact regarding issues with the fire alarm systems at all three sites.

We saw evidence that regular checks were undertaken on the fire alarms and extinguishers and the last check had been carried out in March 2014.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told any updates were circulated to staff and where appropriate, discussed at clinical meetings.

The GPs and nurses told us they lead in specialist clinical areas such as diabetes and heart disease, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice also held clinics to meet the needs of the practice population and where possible patients with multiple conditions were seen in one clinic; these included those patients with long-term conditions such as diabetes and asthma. Other clinics included; well-person and family planning, minor surgery and antenatal clinics.

We spoke with one GP who was able to explain how they had been involved in the development of a care plan to support an elderly patient to stay at home, by discussing at multi-disciplinary team meetings, involving the McMillan nurses and ensuring carers were appropriately co-ordinated.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included; Musculoskeletal referrals, urgent cancer referrals and minor surgery consent and histology. We saw the practice had identified learning from the audits. For example, following the consent and histology audit the practice had introduced a safety mechanism to ensure histology reports were not missed. A log of all histology samples was kept and the practice periodically checked the log to ensure the report had been received.

Doctors in the surgery undertake minor surgical procedures in line with their registration and NICE guidance. Staff are appropriately trained and keep up to date.

We saw the practice had a system in place for monitoring patients with long term conditions and this included learning disabilities.

Additionally the practice monitored their performance against the local Quality and Outcomes Framework (QOF) targets and had achieved a high percentage (93%) against the clinical outcomes. We saw evidence that audits were carried out to monitor performance in specific areas for example; urgent two week wait cancer referrals and musculoskeletal conditions.

We saw minutes of a clinical meeting where mental health recalls had been discussed. The practice had acknowledged that due to incorrect use of the clinical system, some patients had been missing the GP element of their appointment and only seeing the nurse for bloods. We saw actions had been identified and recorded in the minutes of the meeting to rectify this.

Effective staffing

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included clinical and non-clinical staff.

We spoke with three members of the reception team who told us they had received induction training when starting the job. They told us they felt supported to carry out their role when left unsupervised and always had access to support when necessary.

Staff received annual appraisals and felt supported by management and GPs. However; some non-clinical staff told us they would find more regular one to one meetings with management useful.

Two members of the reception team told us how they were given opportunity to develop during their annual appraisals. This was through internal and external learning courses.

We were able to review the induction checklist and induction pack which was used to support trainee doctors at the practice and saw that this was comprehensive and covered all relevant areas.

Are services effective?

(for example, treatment is effective)

The practice held a record of training for all staff. This included information governance, fire safety and safeguarding. Staff also confirmed they received training specific to their roles and this included, cytology update, NHS health check and childhood immunisations.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There were systems in place in relation to receiving, passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results, was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every six weeks to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

We spoke with staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us how they referred patients for secondary (hospital) care and tried to book an appointment using the choose and book system.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. 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. Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We saw the practice website was used to provide and receive information from patients. For example; patients could update the address and telephone number held by the practice electronically. Information was also available for patients advising that medical records could be accessed and how to go about this.

Consent to care and treatment

We found healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). They confirmed their understanding of capacity assessments and how these were an integral part of clinical practice. They were also able to explain the need for Gillick competency assessments of children and young people. This is to check whether these patients have the maturity (at age 16 years or younger) to make decisions about their treatment. Clinical staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Health promotion and prevention

All new patients were required to complete a new patient registration form and attend a medical appointment with the health care team. This was to ensure any existing health issues or medication requirements were identified and managed.

The practice nurses were responsible for the recall, monitoring and health education for people with long term conditions (LTC) and these included conditions such as Asthma and Diabetes. The clinical staff had a clear understanding of the number and prevalence of conditions being managed by the practice. They told us how patients were called for review annually or more regularly where required. GPs at the practice told us how they tried to treat patient with more than one LTC holistically and carry out all the necessary reviews during one appointment.

Are services effective?

(for example, treatment is effective)

Patients at the practice had access to services from Health Trainers. The role of the health trainer is to increase healthy behaviour and uptake of preventative services.

We saw flu clinics were widely advertised throughout each of the branches. We spoke with the GPs who told us the percentage of flu uptake for patients aged 65 and over was high.

The practice had health information readily available and this included breast cancer, dementia, cervical screening and Ebola.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. However a six comment cards mentioned dissatisfaction with the recent changes to the appointment system.

We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. However some patients told us the reception staff could be rude on occasion.

Staff were familiar with the steps they needed to take to protect people's dignity. The practice had an electronic booking system for those who did not wish to announce their name to reception staff. There were rooms available for patients who required a conversation with reception staff in private.

The results of the practice survey dated 2013, showed 82% of patients stated they felt they were treated with dignity and respect by clinical staff, 82% said they were happy with the clinical care received and 80% said they felt the staff were approachable.

Care planning and involvement in decisions about care and treatment

Patients told us they had been involved in decisions about their care and treatment. They told us their treatment was explained to them and they understood the information before giving consent.

We were told patients had a chance to ask questions during a consultation and everything was explained.

Patient/carer support to cope emotionally with care and treatment

We saw information in the practice about advocacy, bereavement support and counselling services. Staff were also aware of contact details for these services when needed.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. 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.

Palliative care meetings with clinical staff and community health professionals were held to discuss patient treatment, care and support. This ensured they received co-ordinated care and support.

The practice website contained information with the option of translating into different languages. The website also contained links to other websites for health related information. For example: the Leeds Cancer Centre and Yorkshire Heart Centre.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

The practice manager told us they had struggled to recruit patients onto the patient participation group and at the time of the inspection only had one patient involved. This was considered a priority for the practice. We saw there was information available across all three sites inviting patients to join the group and information available on the website.

The practice had recently made changes to the appointment system as a result of patient feedback and offered extended hours in order to make more appointments available to patients.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. For example, the practice had systems in place which alerted staff to patients with specific needs or who may be at risk.

Home visits were offered and the practice had links with local residential care and nursing homes. There was good disabled access to the building and patient areas were sufficiently spacious for wheelchair and pram access. Accessible toilet facilities were available for all patients, including baby changing facilities.

Staff told us they had access to translation services during consultations using language line (a telephone based system) for patients who did not have English as a first language and longer appointments were offered to accommodate the use of this service.

Access to the service

The surgery opening times were detailed in the practice leaflet which was available in the patient waiting room and on their website. Patients were able to access appointments at any of the three sites.

Leeds City Medical Practice and Parkside Surgery offered a range of appointments between 8.00am and 6.00pm Monday to Friday. With extended hours being provided between the hours of 6.30-8.30pm on Monday evenings at Leeds City Medical Practice and between 7.30-8.00am on Thursday mornings at Parkside Surgery. The surgeries were closed from 12.00pm on the second Tuesday of every month for training purposes.

The Crossland Surgery opening hours were: Monday from 12.00pm-6.00pm, Tuesday-Thursday from 9.00am-12.00pm and Friday from 9.00am-12.00pm.

When the practice was closed, out of hours cover for emergencies was provided by the NHS 111 service.

Results from the national patient survey demonstrated patients were happy with most aspects of the service. However patients were unhappy with the number of GP and nurse appointments available. The practice had made changes to the appointment system to improve this. For example, removing the open access surgery to reduce the number of face to face appointments that had been accessed for minor issues such as sick note requests and prescription requests. These issues could then be dealt with by telephone which would free up face to face appointments for more serious issues.

By removing the open access surgery, the practice were then able to offer book on the day appointments and book in advance for patients.

Patients could access appointments by telephoning the practice, attending the practice in person or booking on line.

The GPs and staff told us emergency, same day appointments were always available. Home visits were also available where appropriate, and included visits to patients who were house-bound.

Nurse appointment could be booked routinely for a variety of conditions and health promotion, including: Asthma, COPD, Hypertension and Diabetes.

Are services responsive to people's needs?

(for example, to feedback?)

Repeat prescriptions were available to re-order either in person, on-line, posted, faxed or emailed. Information relating to this was available in the practice leaflet and on their website.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handles all complaints in the practice.

We saw information was available to help patients understand the complaints system and this was located in the practice leaflet, in the waiting room and on their web site.

Patients we spoke with were unaware of the process to follow if they wished to make a complaint. They told us this was because they had not had cause to make a complaint.

We reviewed three complaints received by the practice in 2014 and saw they were responded to in line with the practice procedure. We were also told by the practice manager the outcomes of complaints, actions required and lessons learned were shared with staff during their team meetings where appropriate; this was confirmed by nursing and reception staff.

Are services well-led?

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

Our findings

Vision and strategy

There was an established management structure within the practice. The practice manager, GPs and staff were clear about their roles and responsibilities and the vision of the practice. They worked closely with the local CCG and were committed to the delivery of a high standard of service and

patient care.

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's vision and values included supporting the population to achieve good health outcomes and delivering the best possible care.

Staff told us the practice vision and values were embedded within the culture of the practice. They told us the practice was patient focused; they spoke positively about the leadership and felt valued as employees.

Monitoring took place, and this included audits to ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well led care of a high standard at all times.

Governance arrangements

The practice had effective management systems in place. The practice had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation, were in date; reviewed and updated.

We found clinical staff had defined lead roles within the practice. For example, the management of long term conditions, safeguarding children and adults and significant events.

Records showed and staff confirmed that they had up to date training in their defined lead role.

The practice held meetings where governance, quality and risk were discussed and monitored.

One of the lead GPs regularly met and worked with the local CCG, and the practice used the Quality and Outcomes Framework (QOF) to measure their performance. We were told the clinical team regularly discussed QOF data at their meetings and where appropriate action plans were agreed, monitored and reviewed.

Leadership, openness and transparency

The practice was committed to on-going education, learning and individual and team development of staff. The performance of staff was the subject of monitoring and appraisal at all levels; which reflected the organisational objectives.

There was good communication between staff. The practice had a proactive approach to incident reporting. They discussed if anything however minor could have been done differently at the practice.

We were able to review a range of policies including sharing and acting on clinical guidance, formularies, medical device alerts and safety alerts protocol. This clearly outlined the individual responsible for disseminating information and who this should be sent to.

Staff we spoke with told us all members of the management team were approachable, supportive and appreciative of their work. They were encouraged to share new ideas about how to improve the services they provided. Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals.

Practice seeks and acts on feedback from its patients, the public and staff

The practice gathered feedback from patients through the NHS patient survey, comment cards and complaints received. The staff felt they could raise concerns at any time with either the GPs or practice manager, as they were considered to be approachable and responsive. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Although the practice had established a Patient Participation Group (PPG), they had struggled to recruit patients' to join this. The practice manager told us this was considered a priority. We saw there was information in the waiting areas and on the practice website inviting people to join the group.

Management lead through learning and improvement

Are services well-led?

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

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us annual appraisals took place, which included a personal development plan. We looked at two staff files and saw evidence of this.

The practice had completed reviews of significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients. The incidents reported by the practice included medication errors, delayed diagnosis and patient information errors. We saw evidence of this in minutes of meetings and logs of events/incidents.