West Lodge Surgery

Inspection report

New Street
Farsley
Pudsey
West Yorkshire
LS28 5DL
Tel: 01132570295
www. westleedsfamilypractice.co.uk

Date of inspection visit: 7 June to 7 June 2018
Date of publication: 03/08/2018

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?	Outstanding
Are services well-led?	Good

Overall summary

This practice is rated as Good overall but Outstanding for providing responsive services and requires improvement for the population group of people with a long term condition. (The previous comprehensive inspection was carried out in September 2016 when the practice was rated Good overall).

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Good

We carried out an announced comprehensive inspection at West Lodge Surgery on 7 June 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The practice had been proactive in taking steps to meet the requirements of the Accessible Information Standard. This included development of a presentation and training document which was delivered and shared across West Leeds. The practice had information readily available in a range of formats including audio and braille.
- There was a strong focus on innovative practice and partnership working to improve population health in the community. For example; one of the GP partners had taken the lead on the Leeds West Pilot for Deep Vein Thrombosis Pathway.
- The practice was working in partnership with Yorkshire Ambulance Service to have a specialist paramedic to provide clinical care to patients in the community. The scheme was designed to provide help to improve aspects of care provided to patients; help GP surgeries with high workload and increase the skill level of the paramedics involved.

We saw areas of outstanding practice:

- GPs at the practice liaised with other sectors when co-ordinating annual care plans for learning disabled patients and, following discussions and agreement with the patient and their carers, would arrange for integrated multispecialty clinics to integrate blood tests with dental, vision and ear checks if the patient required these. Early dementia screening was also carried out as the practice recognised that learning disabled patients can start to show signs of dementia from the age of 40.

The areas where the provider **should** make improvements are:

- Review and improve the range of vaccinations and immunisations offered to staff in line with Department of Health Guidelines.
- Continue to review and improve quality and outcomes framework exception reporting, particularly around the care and treatment provided to patients with long term conditions.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a second CQC inspector.

Background to West Lodge Surgery

West Lodge Surgery operates from three locations within the West Leeds area. We conducted the majority of our inspection at West Lodge Surgery which is located on New Street, Pudsey, West Yorkshire, LS28 5DL.

We also visited the two branch sites as part of our inspection. Glenlea Surgery which is located at 703 Leeds and Bradford Road, Stanningley, LS28 6PE and Calverley Surgery which is located on Upper Carr Lane, Calverley, LS28 5PL.

West Lodge Surgery operates from a converted, three storey building. Clinical care is provided from the ground floor only. There are on-site parking facilities, including dedicated space for those with limited mobility. The website address is

The practice is situated in the NHS Leeds Clinical Commissioning Group (CCG) and provides primary medical services under the terms of a Personal Medical Services (PMS) contract. This is a contract between general practices and NHS England for delivering services to the local community. There are currently 18,976 patients registered on the practice list.

The practice also worked within the Pudsey locality, along with four other local practices.

The Public Health National General Practice Profile shows that around 5% of the practice population are of black or other mixed ethnicity, with 95% of white British origin. The level of deprivation within the practice population group is rated as six, on a scale of one to ten. Level one represents the highest level of deprivation, and level ten the lowest.

The practice offers a range of clinics which include sexual health, chronic disease management and childhood vaccinations and immunisation.

West Lodge Surgery is registered with the Care Quality Commission to provide the following regulated activities:

- Maternity and midwifery services
- Treatment of disease, disorder or injury
- Family Planning
- Diagnostic and screening procedures
- Surgical Procedure

The service is provided by six GP partners (two male and four female) and seven salaried GPs (three male and four female). The GPs are supported by an advanced nurse practitioner, three practice nurses and a trainee practice nurse (all female). Completing the clinical team are four health care assistants (two male and two female) and a practice pharmacist (female).

The clinical team is supported by a practice manager, an assistant practice manager and an experienced team of reception and administrative staff.

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

The practice is open between the hours of 7.30am and 6.30pm with a range of appointments offered between these hours. In addition, the practice works with another four practices in the Pudsey locality to offer extended hours via a hub service from 6pm until 8pm Monday to Friday, from 8am until 1pm on Saturday and from 8am until 12pm on Sunday.

Out of hours care is provided by Local Care Direct which is accessed by calling the surgery telephone number, or by calling the NHS 111 service.

When we returned to the practice, we checked, and saw that the ratings from the previous inspection were displayed, as required, on the practice premises and on their website.

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. Clinicians within the practice had actively raised awareness of domestic violence with staff. Clinical staff opportunistically screened for domestic violence during six week baby checks and asked parents "do you feel safe in your home". The same question was asked in other clinical settings where appropriate. In addition; the practice had a system to highlight any child who had five or more contacts with health services within a 12 month period and appropriate checks could be carried out.
- All staff received up-to-date safeguarding and safety training; however we noted that two GPs had not undertaken level three safeguarding training at the time of our inspection. We received confirmation from the practice following our inspection that this training had been undertaken.
- Staff knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a 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.)
- 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.
- There was an effective system to manage infection prevention and control. However; at the time of our inspection the practice were not offering full vaccination screening in line with Department of Health recommendations in relation to varicella (chicken pox).
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens 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 an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- 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.
- 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. The practice had introduced recognised clinical templates to ensure standardised care in line with current evidence based guidelines.
- 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

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.
- 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 on 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.
- 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.
- 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 as good for providing effective services overall and across five of the six population groups. We rated the population group of people with a long term condition as requires improvement for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice website contained a 'managing your health' section which described various symptoms and how these could be treated.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had implemented new clinical templates which incorporated a clinical decision support tool. This enabled clinicians to access evidence-based resources and guidance.
- 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. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication. The practice had identified a need for an improvement of coding on the clinical system for frail patients and could demonstrate an improvement in this area. In 2016/17 the practice had one patient coded as severely frail, five as moderately frail and 16 as mildly frail. Work had been undertaken to review and improve coding and at the time of our inspection the practice had 218 patients recorded as severely frail; 260 patients as moderately frail and 478 as mildly frail.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

We rated this population group as requires improvement because we saw that the practice had a higher rate of exception reporting for some of the Quality and Outcomes Framework (QOF) indicators. QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

- 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).

Families, children and young people:

- The practice had achieved 97% uptake of childhood immunisation across all age groups. This was above 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.

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

Good

Are services effective?

- The practice's uptake for cervical screening was 79%, which was in line with the 80% coverage target for the national screening programme.
- The practice's uptake for breast and bowel cancer screening was above the national average.
- 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 to74. The practice had identified the need to improve the uptake of health checks for men and had responded to this by introducing a birthday card which invited them to attend the practice for a health check. In addition; they were carried out opportunistically. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

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 prioritised patients receiving end of life care and each patient had a named GP.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered annual health checks to patients with a learning disability. The practice used easy read templates to support patients with the health check.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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.

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.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

- 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.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- 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. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing 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.

Good

Are services effective?

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- 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 care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local 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 that 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.

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. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- 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, 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 generally 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 practices GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

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 and had been proactive in taking steps to meet this. The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information that they are given.

- Staff communicated with people in a way that they could understand. For example; the practice leaflet; complaints procedure and complaints forms were readily available for patients in audio, braille and large print.
- We saw an example of how clinicians within the practice supported patients to be involved with decisions about care and treatment. Patients were given written personalised information about the risks and benefits of noval oral anticoagulant (NOAC) and warfarin. This approach supported shared decision making with patients.
- 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 practices GP patient survey results were in line with local and national averages.

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.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, and two of the population groups (Families, children and young people and People whose circumstances may make them vulnerable), as outstanding for providing responsive services. We rated the remaining four population groups as good.

We rated the practice as outstanding for providing responsive services because:

- The practice had been proactive in taking steps to meet the requirements of the Accessible Information Standard. This included development of a presentation and training document which was delivered and shared across West Leeds. The practice had information readily available in a range of formats including audio and braille.
- The practice had a dedicated GP lead for patients with a learning disability. The GP lead actively engaged with other sectors when co-ordinating annual care plans. The practice routinely used an easy read annual health check template to support this group of patients.
- The practice had good systems in place to identify and support vulnerable adults and children.

The practice worked in collaboration with four other local practices as part of the Pudsey Locality Group to identify the needs of the local population and develop additional services to meet the needs of patients.

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. The practice worked in collaboration with four other local practices as part of the Pudsey Locality Group to provide a range of additional services to meet the needs of patients.
- The practice had worked to offer specialist clinics from a community setting. For example; ultrasound services; PhysioFirst, Patient Empowerment Project clinics.
- The practice was working in partnership with Yorkshire Ambulance Service to have a specialist paramedic to provide clinical care to patients in the community. The scheme was designed to provide help to improve aspects of care provided to patients; help GP surgeries with high workload and increase the skill level of the paramedics involved.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice worked with other local practices to provide additional extended hours from 6pm until 8pm Monday to Friday; from 8am until 1pm on Saturday and from 8am until 12pm on Sunday.
- 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.
- The practice had information for patients about the services available that was easy to understand and accessible. For example; the practice leaflet, complaints procedure and complaints forms were readily available for patients in audio, braille and large print. In addition the practice routinely used an easy read annual health check form produced by the Learning Disability Service. Patients were invited for an appointment with the GP and the form would be completed during this appointment.
- The practice had easy read information on Abdominal Aortic Aneurysm (AAA) screening to support patients through this process.
- The practice had installed acoustic panels to reduce the amount of echo in the building and to assist patients who were hard of hearing.
- 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 part of the care home scheme, a GP led service which was supported by the practice

Are services responsive to people's needs?

pharmacist. The service aimed to improve care by proactively reviewing patients who were resident in nursing or residential homes for older people on a regular scheduled basis.
- The practice had a dedicated lead for detecting frailty using a frailty register which enabled them to provide appropriate support. The practice had identified 213 new diagnoses in the previous 12 months.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice had good links and regularly sign posted to local organisations intended to support the elderly.

People with long-term conditions:

- The practice had noted a need for improvement in identification and management of atrial fibrillation and had purchased a portable electrocardiogram (ECG) recorder to screen patients who were unable to access the surgery in person. The information was then loaded onto the patient record to be reviewed by a clinician and the appropriate action taken. In addition; the practice initiated warfarin and other noval oral anticoagulants (NOAC) within the practice. Patients were given written personalised information about the risks and benefits of noval oral anticoagulant (NOAC) and warfarin. This approach supported shared decision making with patients.
- The practice had been involved in diabetic speciality training and education as part of locality working to enable in-house insulin initiation by the nursing team. Health care assistants at the practice were also trained to do foot checks.
- The practice offered domiciliary blood and long term conditions reviews as part of the locality phlebotomy service.
- The practice used NHS health checks to identify pre-diabetes and had referred 80 patients to the NHS Diabetes Prevention Programme within the last 12 months.
- One of the GP partners had taken the lead on the Leeds West Pilot for Deep Vein Thrombosis Pathway. The pilot included looking at ways to improve compliance with NICE guidelines, by increasing the number of patients being treated with anticoagulant within four hours to 100%, improving patient flow and reducing costly visits to secondary care by streaming through a primary care setting.
- We saw that 29 patients had been referred via the new pathway from 14 November 2017 to 26 April 2018.
- 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 held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

We rated the practice as outstanding for providing responsive services to this population group. This was because:

- The practice was proactive in their approach to safeguarding children and vulnerable adults from abuse. Clinicians within the practice had actively raised awareness of domestic violence with staff. Clinical staff opportunistically screened for domestic violence during six week baby checks and asked parents "do you feel safe in your home". The same question was asked in other clinical settings where appropriate. In addition; the practice had a system to highlight any child who had five or more contacts with health services within a 12 month period and appropriate checks could be carried out.
- Post-natal and baby checks were carried out at the practice. In addition; the practice had continued to work within the requirements of the paediatric asthma project. This project was originally funded by the Clinical Commissioning Group until April 2017. However; the practice had continued to carry on with the project which included carrying out monthly searches to identify children with asthma, sending annual reminders to parents as a prompt to restart inhalers and carrying out checks in line with standard asthma indicators.
- The practice had worked with the Pudsey Locality to establish an integrated childrens hub which would be hosted at Glenlea Surgery. This service was scheduled to commence in September 2018 and would provide an open access email for advice and guidance from the

Are services responsive to people's needs?

paediatric department, peer support groups (for example asthma; autism and obesity groups), health promotion and multidisciplinary clinics. The aim of the hub was to reduce paediatric admissions and decrease accident and emergency department attendance.

We also found:

- 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. For example, telephone consultations and extended opening hours.
- The practice had introduced a new website with additional services being offered such as sick note requests and repeat prescriptions.
- The practice had actively encouraged online services and uptake had increased from 18% to 27% within the previous 12 months.
- The practice had been the first in the country to utilise the electronic prescription service (EPS). The EPS enabled the GP practice to send a prescription directly to the pharmacy of choice. This reduced the need for the patient to return to the practice to collect it.

People whose circumstances make them vulnerable:

We rated the practice as outstanding for providing responsive services to this population group. This was because:

- The practice had a lead GP who ran a monthly learning disability clinic. The GP liaised with other sectors when co-ordinating annual care plans for learning disabled patients and, following discussions and agreement with the patient and their carers, would arrange to integrate blood tests with dental, vision and ear checks if the patient required these. Early dementia screening was also carried out as the practice recognised that learning disabled patients can start to show signs of dementia from the age of 40.
- The practice used an easy reading template to support uptake of the health check for patients with a learning disability. This was given to the patient and their carer two weeks prior to the appointment. The template was then completed by the patient and GP during the review.
- The practice had information for patients about the services available that was easy to understand and accessible. For example; the practice leaflet, complaints procedure and complaints forms were readily available for patients in audio, braille and large print. In addition the practice routinely used an easy read annual health check form produced by the Learning Disability Service. Patients were invited for an appointment with the GP and the form would be completed during this appointment.
- The practice had easy read information on Abdominal Aortic Aneurysm (AAA) screening to support patients through this process.
- The practice had installed acoustic panels to reduce the amount of echo in the building and to assist patients who were hard of hearing.

We also found:

- 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):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- The practice regularly sign posted to voluntary services. For example; 'mind well'.

Outstanding ☆

Are services responsive to people's needs?

- The practice was working with the patient empowerment project to host a regular clinic upon completion of the planned extension at West Lodge Surgery.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- 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.
- Some patients reported that the appointment system could be improved and the practice were continually reviewing this was easy to use.

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 actively rewarded excellent performance from staff via an employee of the month award.
- The practice was proactive with regard to locality working and improving services for patients. One of the GP partners was a director of the Leeds West Primary Care Network and was actively involved with the Leeds Clinical Commissioning Group.
- The practice was a training practice and accommodated medical students, GP trainees and GP Registrars. GP Registrars are fully qualified doctors who are completing their specialist training to become a GP. At the time of our inspection the practice were looking to have nurses in training to be attached to the practice for their placement.
- Many of the current workforce at the time of the inspection had previously worked at the practice as GP registrars, and had been supported by the practice during training.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The practice had identified succession planning as a key objective and could demonstrate detailed plans and work undertaken to identify successors to current GP leads.

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 had 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 strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice worked closely with four other practices in the Pudsey locality to drive improvement for the local population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- 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 needed. 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. For example; personal alarms were provided for staff to use on the way to and from work; there was a policy in place to ensure staff finished work and left the building in pairs. In addition a protocol was in place for any staff member arriving to open up the practice on a morning to keep the door locked until another member of staff arrived.
- 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

Good

Are services well-led?

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

- 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
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

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.
- 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 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 had a business continuity plan in place and a disaster recovery kit located on site. The disaster recovery kit contained a heat wrap; laptop; flashlight; high-visibility jacket and a clipboard. As part of the business continuity plan one member of staff took a laptop home each day to enable remote access in the event of a major incident.
- 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. Performance information was combined with the views of patients.
- 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.
- 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.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

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 were high levels of staff satisfaction. The feedback we received from all staff members was overwhelmingly positive about their role and the culture of the practice. The practice could demonstrate how they supported staff both in the workplace and placed high regard on the health and wellbeing of every staff member.
- There was an active patient participation group (PPG). However; we were advised that there had been difficulties getting patients to join the PPG and retaining the patients that did join. The PPG was working closely with the practice manager to increase representation.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. For example; at the time of inspection the practice was in the process of mentoring and supporting a health care assistant to progress to a practice nurse.

Good

Are services well-led?

- All staff members received a dedicated allowance of time to undertake training and development. Funding for training was also provided by the practice.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice engaged in local and national initiatives. For example; the practice had been involved in the paediatric asthma projected which was funded by the Clinical Commissioning Group until April 2017. However; the practice had continued to carry on with the project; carrying out monthly searches to identify children with asthma and sending letters on an annual basis to parents to prompt them to restart inhalers.

Please refer to the evidence tables for further information.