Oakwood Lane Medical Practice

Quality Report

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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?	**Outstanding**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Oakwood Lane Medical Practice on 7 July 2015.

Specifically, we found the practice to be good for providing safe, effective responsive and caring services. It was outstanding for being well led. It was also outstanding for providing services for people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). It was good for the other population groups.

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

- The practice had robust systems in place to safeguard patients from potential abuse. Staff were appropriately trained in safeguarding and one GP was the named GP for safeguarding children at the Clinical Commissioning Group (CCG). Learning from safeguarding board meetings and child protection reviews was disseminated widely within the practice.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice health champions worked with the local sports centre to deliver a twelve week programme of chair based exercises.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure they meet people's needs.

Summary of findings

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Forum group.
- 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
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw two areas of outstanding practice including:

- The practice had invested in the co-production model of healthcare and trained a group of volunteer patients by a third sector organisation to become practice health champions. A designated area within the practice called 'The Roost' was used as a community hub for patient health champion activities. The champions had established a weekly crafting group to address social isolation, a weekly chair based exercise group, to help introduce people to exercise, and a weekly walking club. They had also opened a café within the area to be used as a drop in for various other activities they had planned.
- Staff at the practice continually reviewed access to appointments by analysing the number of telephone calls to the practice and appointment requests to predict call to plan staff rota requirements both to answer the telephone calls and also provide appointments for patients.

However there was an area of practice where the provider needs to make improvements, importantly the provider should:

- Ensure all staff who handle and manage complaints are trained to do so. Ensure written complaint responses reflect guidance in the practice complaints policy.

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. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was embedded and recognised as the responsibility of all staff. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines. We also saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. Data showed the practice was performing comparably to neighbouring practices in the CCG. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The practice co-funded, with other practices in the area, a social connector role to support patients' focus on their social networks and relationships and address issues of loneliness and isolation. The practice had invested in training a group of volunteer patients by a third sector organisation to become practice health champions.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice comparable to others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

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 England Local Area Team and CCG to secure improvements to services where these were identified. Patients said it was sometimes difficult to get through to the practice by telephone first thing in the morning. Staff had identified this as an area for improvement and

Summary of findings

were acting on it. Patients told us there was continuity of care, with urgent appointments available the same day. 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 the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding 

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality, learning and safety as its top priorities. The vision had been produced during the merger of two previous practices and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using various methods, including through practice health champions, and it had a very active patient forum.

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 patients. . Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Staff at the practice linked in with third sector organisations to provide additional support to patients.

People with long term conditions

Good

The practice is rated as good for the care of patients with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits by the GP and advanced nurse practitioner were available when needed. The pharmacist would review those patients taking multiple medicines. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation uptake rates were relatively high for all standard childhood immunisations. The practice combined mother and baby health checks with first immunisations and this assisted in maintaining high immunisation rates. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. The lead GP for child safeguarding regularly attended the local safeguarding board and was the named GP for safeguarding children at the CCG.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. Telephone appointments were available and the practice offered appointments first thing in the morning. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability. The practice regularly worked with multidisciplinary teams in the case management of vulnerable patients. GPs had protected time to contribute to reports and attend case conferences. It informed vulnerable patients how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours. The practice had also identified a higher incidence of reported incidents of domestic abuse between April 2014 and March 2015 in local area. They had developed a protocol offering support, advice and signposting to other organisations and a place of safety within the premises to contact the external agencies from. They identified a higher incidence of self-harm in young people proactively provided them with an early help approach offering support, advice and signposting to other organisations to support mental health and well-being.

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is outstanding for the care of patients experiencing poor mental health (including people with dementia). Data showed the practice achieved 98.8% of the national targets for caring for patients with severe mental health problems including undertaking physical health checks. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Talking therapies were available on site. The practice carried out care planning for patients with dementia. There was evidence of

close liaison with community mental health teams and with local consultants. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.	

Summary of findings

What people who use the service say

Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 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. Five comments were less positive; two relating to issues with repeat prescriptions and two patients we spoke with reported similar issues with repeat prescriptions not being ready on time or not containing all the correct items. There were no common themes to the others.

We also spoke with twelve 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. We spoke with eight practice health champions. They were extremely enthusiastic about the training they had undertaken, supported by the practice, to become a practice health champion. They told us how they were supported by the practice team in their roles and how the sessions they facilitated had started to make a difference for patients who attended. We spoke with six members of the patient forum. They told us how the forum split into groups to support the practice in different areas. For example, suggested improvements for the website, reviewing communications to patients and reviewing the practice complaints policy. Some told us the work they had completed had not yet been implemented.

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

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from July 2015 (28% response rate) and a survey of 117 patients undertaken by the patient forum in February 2015. The information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. Respondents to the national GP patient survey reported:

- 49% find it easy to get through to this surgery by phone compared with a CCG average of 79% and a national average of 73%.
- 83% find the receptionists at this surgery helpful compared with a CCG average of 88% and a national average of 87%.
- 45% with a preferred GP usually get to see or speak to that GP compared with a CCG and a national average of 60%.
- 76% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.
- 86% say the last appointment they got was convenient compared with a CCG and a national average of 92%.
- 60% describe their experience of making an appointment as good compared with a CCG average of 77% and a national average of 73%.
- 68% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 72% and a national average of 65%.
- 48% feel they don't normally have to wait too long to be seen compared with a CCG average of 61% and a national average of 58%.

Areas for improvement

Summary of findings

Action the service SHOULD take to improve

- Ensure all staff who handle and manage complaints are trained to do so. Ensure written complaint responses reflect guidance in the practice complaints policy.

Outstanding practice

- The practice had invested in the co-production model of healthcare and trained a group of volunteer patients by a third sector organisation to become practice health champions. A designated area within the practice called 'The Roost' was used as a community hub for patient health champion activities. The champions had established a weekly crafting group to address social isolation, a weekly chair based exercise group, to help introduce people to exercise, and a weekly walking club. They had also opened a café within the area to be used as a drop in for various other activities they had planned.
- Staff at the practice continually reviewed access to appointments by analysing the number of telephone calls to the practice and appointment requests to predict call to plan staff rota requirements both to answer the telephone calls and also provide appointments for patients.

Oakwood Lane Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, two inspectors, a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

Background to Oakwood Lane Medical Practice

Oakwood Lane Medical Practice in Leeds was formed in 2014 following the merger of Chapeloak Practice and The Lodge Surgery.

The practice provides services for 12,708 patients under the terms of the locally agreed NHS Personal Medical Services contract. The practice catchment area is classed as within the group of the second most deprived areas in England. The age profile of the practice population is broadly similar to other GP practices in the Leeds North Clinical Commissioning Group (CCG) area.

The newly formed practice moved into the new purpose built premises in September 2014. There are eight GP partners, two male and six female, who work at the practice. They are supported by four salaried GPs, all female, an advanced nurse practitioner, five practice nurses, two healthcare assistants, a practice manager, an operations manager, pharmacists and a team of administrative staff.

The practice is open weekdays from 7am to 6pm. Calls to the practice between 6pm to 6.30pm are answered by the out-of-hours service. GP and practice nurse appointments are available at various times throughout the day from 7am to 5.40pm Monday to Friday with times scheduled to meet predicted demand. Patients contacting the practice for an urgent appointment would speak to the on call GP and an appointment arranged that day if needed. Minor surgery, diabetes, asthma, family planning, antenatal and mother & baby clinics are run each week. Out-of-hours care is provided by Local Care Direct and is accessed via the surgery telephone number or calling the NHS 111 service.

Oakwood Lane Medical Practice is registered to provide; diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and the treatment of disease, disorder or injury from 2 Amberton Terrace, Leeds, LS8 3BZ.

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed information we hold about the practice and asked Leeds North CCG and NHS England to share what they knew. We carried out an announced visit on 7 July 2015. During our visit we spoke with the three GPs, the practice manager, the operations manager, a pharmacist, a practice nurse, the advanced nurse practioner, five members of the administrative team and the social connector. We also spoke with 12 patients who used the service and reviewed 30 comment cards. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment 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)

Good

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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we were shown details of an incident reported relating to two specimens labelled with the same patient details. The patients were contacted and given an apology and asked to attend again for the specimens to be taken at a time convenient to them. We saw the procedures for labelling specimens was reviewed. It included all specimens to be labelled using the integrated clinical environment (ICE) system at the time the specimen was taken. Staff we spoke with told us they had received details of the incident via their line manager and email and were following the updated procedure.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. We saw investigations and outcomes were documented. Follow up actions were documented but did not always include details of when they were completed. We were told the GPs and practice manager had identified this and were scheduling a quarterly review meeting to review the progress of actions and document accordingly. Of the incidents reviewed, staff at 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

There was a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events which had occurred during the last year and saw this system was followed appropriately. Significant events were a standing item on the weekly clinical meeting agenda and a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including pharmacists, receptionists, administrators and nursing staff all knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff reported incidents to their line manager, senior GPs or the practice manager. Incident forms were then completed and placed on the agenda for the weekly clinical meeting. We reviewed the incident log and the minutes of meetings available to us where significant events had been discussed. GPs told us the meetings were not recorded every week due to minute taker availability. On those occasions the attendees would keep an individual note of actions agreed. All incidents we reviewed were recorded, discussed and completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, an incident was reported by a member of staff when a patient was given the same medicine during two separate home visits. The procedure to check the patient's identity during home visits had been reviewed and updated to prevent a similar occurrence happening in the future. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at weekly clinical meeting to ensure all staff were aware of any relevant to their practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had embedded systems to manage and review risks to children and adults whose circumstances may make them vulnerable. They had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children with another GP who supported this work. Both had been trained in adult and child safeguarding to level three and could demonstrate they had the necessary competency and skills to enable them to fulfil these roles. The lead GP was also the named doctor for children's safeguarding for the city of Leeds. There was evidence learning from attendance at safeguarding board and case reviews were shared with other members of the practice team. For example, new protocols were disseminated and GPs were made aware of the need to follow up children who attended the practice regularly. All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

Good

Are services safe?

We looked at training records which showed all staff had received relevant role specific training in safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in those whose circumstances may make them vulnerable. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Staff provided recent examples of where referrals were made and subsequent partnership working with the local authority, police and third sector agencies. For example, how they worked with a local support group to move furniture around in a patient's home to promote independence and security. 'Third sector organisations' is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

There was a system to highlight children and adults whose circumstances may make them vulnerable on the practice's electronic records. This included information to make staff aware of any relevant issues when contacting the practice or attending for appointments. For example, walk-in appointments with a named GP for those whose circumstances made them vulnerable.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. 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.

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 policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We were shown regular reviews of prescribing data to identify whether the medicine was prescribed appropriately and to consider if there were any alternative ways of helping patients. For example, patterns of antibiotic prescribing were reviewed to try and reduce the incidence of some antibiotics interfering with the natural balance of normal bacteria in the digestive system. Prescribing staff told us how the bi-annual audit prompted them to refer to the medicine formulary on the patient record system to ensure the correct antibiotic and dose were prescribed. The antibiotic prescribing rate for the practice was 2% lower than the local and national average of 5%.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines which require extra checks and special storage arrangements because of their potential for misuse). Staff carried out regular audits of the prescribing of controlled drugs and they were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in the area.

Good

Are services safe?

The practice nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines which had been produced in line with legal requirements and national guidance. We saw sets of PGDs which had been updated in 2014. In practice this means that a PGD, signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) which had been produced by the prescriber. A PSD is a written instruction, signed by a doctor, dentist, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. We saw evidence practice nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long term conditions such as diabetes and the latest prescribing guidance was being used. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. A pharmacist was employed to review repeat prescriptions for patients with long term conditions or those prescribed multiple medicines. The pharmacist told us this reduced medicine wastage as patients only received the medicine they required. The pharmacist would accompany the GP or the advanced nurse practitioner on home visits to review patient's medicines. Two comment cards and two patients we spoke with reported issues with repeat prescriptions not being ready on time or not containing all the correct items. We reported this to the practice manager who told us the issues would be looked into.

The practice had established a service for patients to pick up their prescriptions at two locations and had systems in place to monitor how these prescriptions were collected. They also had arrangements in place to ensure patients collecting medicines from these locations were given all the relevant information they required.

We saw a positive culture in the practice for reporting and learning from medicine incidents and errors. One of the GP partners took the lead for investigating prescribing incidents. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection prevention 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 prevention and control (IPC).

An IPC 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. Staff were able to describe how they would use these to comply with the policy. Reception staff told us how they would use gloves and an apron for the safe handling of specimens following practice procedure. There was also a policy for needle stick injury and staff could describe what to do in the event of an injury.

The lead for IPC had undertaken further training to enable them to provide advice on the policy and facilitate staff training. All staff received induction training about IPC specific to their role and received annual updates. An IPC audit had been completed in October 2014, shortly after the premises opened. We saw actions identified had been completed. For example, installing mop racks in the cleaning store.

Good

Are services safe?

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.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records to confirm regular checks were being performed in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

We were shown the recruitment policy which set out the standards followed when recruiting clinical and non-clinical staff. We were told an external recruitment company was used to lead recruitment campaigns for staff. Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice manager told us how demand for appointments had been monitored since the partnership formed to plan the number of medical and nursing staff required to work. This had helped the practice explain when there had been an increase in demand for appointments or more patients attending the local accident and emergency department due to local outbreaks of illness.

We saw there was a rota system in place for all the different staffing 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. Newly appointed staff had this expectation written in their contracts. 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. The practice manager showed us records to demonstrate actual staffing levels and skill mix met planned staffing requirements.

Locum GPs were occasionally employed to work at the practice to cover leave. We were shown the locum introduction pack which included the complaints process, how to access language interpreting services, referral forms for radiology and the child and adult safeguarding procedures and a directory of organisations.

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 regular checks of the building, 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 and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with the environment were required to be included on the log. We saw an example of this where mitigating actions had been put in place. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within the weekly clinical meeting.

Arrangements to deal with emergencies and major incidents

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. These included adrenaline (which can be used to treat anaphylaxis) and hydrocortisone (for treating asthma or recurrent anaphylaxis). 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.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies 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. The plan was last reviewed in 2014.

A fire risk assessment had been completed in 2014 which included actions required to maintain fire safety. Records showed staff were up to date with fire training and regular fire evacuation drills were performed.

Good

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 saw guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GPs and nurses how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with chronic obstructive pulmonary disease were having regular health checks and were being referred to other services when required. Feedback from patients confirmed this.

GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, 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. GPs told us this supported all staff to review and discuss new best practice guidelines.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met to assist in reducing the need for them to go into hospital. We saw after patients were discharged from hospital they were followed up to ensure continuity of care.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs demonstrated the culture in the practice was patients were cared for and treated based on need and account of patients' age, gender, race and culture was taken into consideration only when appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment and their outcomes, was routinely collected and monitored. This information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. For example, we saw an audit regarding the prescribing of 'z' medicines used for the treatment of sleep problems. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Oakwood Lane Medical Practice was not an outlier for any QOF (or other national) clinical targets, It achieved 96.5% of the total QOF target in 2014, which was comparable to the national average of 97%. Specific examples to demonstrate this included:

- Performance for diabetes care was lower than the national average.

Good

Are services effective?

(for example, treatment is effective)

- The percentage of patients with high blood pressure having regular blood pressure tests was better than the national average
- Performance for mental health related care was better than the national average.
- The dementia diagnosis rate was comparable to the national average

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed. They had 7% more patients registered with a long term condition compared to the national average, for example diabetic care. We were told how staff had reviewed the annual review process for people with long term conditions including diabetes, COPD, heart failure and dementia in April 2015. The annual review now took place during the month of the patient's birthday. A six monthly interim appointment was also arranged to review the patient. Those with multiple conditions were offered co-ordinated reviews. The practice manager told us this evened out the number of reviews required throughout the year and assisted planning staff rotas. One patient we spoke with told us they had not yet had their review. The practice manager explained as the system had just been introduced in April; those with birthdays later on in the year or beginning of next would not have yet been contacted to attend a review. A notice to inform patients of the change of practise was displayed in the waiting room and on the practice website. Patients were sent a letter inviting them to attend a review when it was due.

The practice had achieved the national targets for care of patients experiencing poor mental health. This included completion of annual physical health checks. We saw patients with dementia had care plans in place which were regularly reviewed and the diagnosis rate of dementia was increasing. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Talking therapies were available on site. We were shown evidence of close liaison with community mental health teams and with local consultants. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. We received positive written comments from patients praising the support the practice offered people with mental health conditions.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting there was an expectation all clinical staff should undertake at least one audit a year.

The practice was working towards the gold standard framework for end of life care. It had a palliative care register and had regular internal as well as six weekly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those whose circumstances may make them vulnerable. For example, those living in supported accommodation.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area. For example, the number of patients with a dementia who attended for an annual review.

Effective staffing

Practice staffing included medical, pharmacy, nursing, managerial and administrative staff. We reviewed staff training records and noted group records of attendance at training were not kept, only individual certificates. We saw from the staff files we reviewed staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with a number having specialist interests in safeguarding, domestic violence, cancer care and co-production. Co-production recognises what people and communities want and could do for themselves and reorienting and reshaping health and other services to support them.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example a diploma in diabetes care.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties. For example, administration of vaccines and cervical cytology. Those with extended roles who reviewed patients with long term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate they had received appropriate training to fulfil these roles.

Staff files we reviewed showed where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications.

Out-of-hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within three days of receipt. 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. There were no instances identified within the last year of any results or discharge summaries were not followed up.

Emergency hospital admission rates of 17% for the practice were just above the national average of 14%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings every eight weeks to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, 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. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care

plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. There was a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. This is used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions. An area on the electronic patient record system prompted the staff member to assess and document Gillick competency when appropriate.

There was a policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

Information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority was analysed by staff to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area. We were told this informed staff that the practice population resided in some of the most deprived and most affluent areas in Leeds.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

Patients aged 40 to 75 years were offered NHS Health Checks. Those who attended were told their lifestyle risk score and given advice to promote healthy lifestyles. We were shown the process for following up patients within two weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. Patients could be referred to an alcohol worker and a health trainer. The practice had also identified the smoking status of 97% of patients with a long term condition and actively offered smoking cessation support to 99% of these patients from an in-house smoking cessation advisor. A weekly mother and baby clinic was held at the practice and those attending had access to a midwife and GP for advice and support.

The practice co-funded with other practices in the area a social connector role, also known as social prescribing, to support patients focus on their social networks and relationships and address issues of loneliness and isolation. Social Prescribing is about linking people up to activities in the community they might benefit from. It can connect people to non-medical sources of support. Following referral from a GP, the social connector would interview patients and develop a plan to connect patients with outside agencies to improve their emotional mental health and wellbeing and promote healthy lifestyle choices. We were told how popular the social connector role was with patients and the appointments quickly booked up.

Performance for the cervical screening programme was 82%, which was just above the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A member of the reception team and a practice nurse were responsible for following up patients who did not attend. They also recognised patient attendance at national screening programmes for bowel cancer and breast cancer screening was lower than the CCG average. Staff told us how during consultations they encouraged patients to attend screening programmes and would provide leaflets encouraging them to take part.

A full range of immunisations for children was offered at the practice along with travel vaccines and flu vaccinations. We were told by staff last year's performance was below

Good

Are services effective?

(for example, treatment is effective)

average for some of the immunisations and vaccines where comparative data was available. For example flu vaccination rates for the over 65s were 9% lower than the local average, and at risk groups were 4% lower.

Following a review serious case review in the local area, staff at the practice told us they designed a template within the patient record system to record all correspondence and follow up for children. The template captured when a child did not attend a health care appointment within the shared patient record. Staff told us how valuable this information was in capturing patterns of non-attendance at appointments. Staff explained how this system had improved the uptake of childhood immunisations as those with frequent non-attendance could be identified and flexible appointments offered. For example, childhood immunisation rates for the vaccinations given to under twos improved by 1% from April to June 2015. Pre-school boosters had increased from 2.5% for the same period.

As part of the co-production health care model led by one of the GP partners, the practice had invested in training a group of volunteer patients by a third sector organisation to become practice health champions. A designated area within in the practice called 'The Roost' was used as a community hub for patient champion activities. The champions had established a weekly crafting group to address social isolation, a weekly chair based exercise group to help introduce people to exercise and a weekly walking club. They had also opened a café within the area to be used as a drop in for various other activities they had planned.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey and a survey of 117 patients undertaken by the practice's patient forum in February 2015.

The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the practice was just above average for patients who rated the practice as good or very good. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 89% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 92% said the nurse was good at listening to them compared to the CCG and national average of 91%.
- 90% said the nurse gave them enough time compared to the CCG and national average of 92%.
- 99% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%

Very similarly, 90% respondents to the patient forum questionnaire provided high ratings for their experience of being treated with dignity and respect by the GPs and nurses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 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. Five comments were less positive; two relating to issues with repeat prescriptions and no common themes to the others. We also spoke with 12 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.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the confidentiality policy when discussing treatments with patients so confidential information was kept private. Telephone calls to the practice were answered in a separate room away from the reception area. In response to the patient forum survey a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted it enabled confidentiality to be maintained. Additionally, 83% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%. Patients we spoke with told us sometimes when they rang the practice they felt their calls were rushed and did not come to a natural end. We fed this back to the practice manager who told us it would be looked into.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where a patient's privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice on the top of the reception desk stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

Good

Are services caring?

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 82% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%.
- 88% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 90%.
- 87% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG and national average of 85%.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us telephone interpretation services were available for those who did not have English as a first language. We saw notices in the reception areas informing those who visited the practice this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

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 including the groups run by the practice health champions. The patient record system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Members of the Leeds carers' group attended the practice once a week to meet with carers and receive referrals from the practice. Staff told us the group provided confidential information, advice and support to carers and patients and those who met with the group spoke highly of their support. The shared record system notified practice staff when a carer was admitted to hospital so the practice could alert other agencies involved in the care of the patient.

Staff at the practice sent a personalised condolence card to families who had experienced bereavement. They were then offered the opportunity to make an appointment to see their usual GP. 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 local support service.

The practice health champions held a weekly 'happy café' for all patients in attempt to address social isolation. Feedback from the champions was the café was well attended and more patients were popping in on a regular basis.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found staff at the practice was responsive to patients' 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. For example, GPs had a walk in and wait arrangement with those patients whose circumstances may make them vulnerable.

One of the GPs was active on the board of the Leeds North Clinical Commissioning Group (CCG) and three others led on specific areas for the CCG. We saw the practice engaged regularly with the CCG and other practices to discuss local needs and service improvements which needed to be prioritised. For example, the practice supported two GPs to complete the Leeds Institute of Quality Healthcare programme looking at access to appointments as an area to improve upon.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback. Members of the patient forum were actively involved in the design of the new practice premises.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. Staff were proactive in monitoring if children or adults attended accident and emergency or missed appointments frequently. We were shown a template on the clinical system which tracked attendance at all healthcare appointments. If patterns of not attending were identified this would be brought to the GP's attention who then worked with other health and social care professionals. We saw minutes of meetings where those who circumstances may make them vulnerable were discussed. Health visitors met with the lead GP for child safeguarding every eight weeks. They had access to the electronic patient record system, via the shared care record, and could update information on children at risk or who gave rise to concern.

We were told the local postcode area in which the practice was located was amongst the highest for reported self-harm in young people. GPs identified referral times to specialist services to support young people were 24 weeks unless the person was acutely suicidal. We were told this was addressed this by embracing an early help approach, which included working in collaboration with school nurses, health visitors and the local children's centre. Representatives from the practice involved in the care of the young person would attend the relevant multi-agency meetings which facilitated discussion on what best service to offer a child and their family. We received positive feedback from patients about the services offered to young people with mental health issues saying staff were accessible and supportive.

Staff at the practice promoted the mindmate website to young people which was developed by the CCG. It provided the opportunity for young people to explore emotional well-being and mental health issues and provided further information about where support was available.

Staff had also identified the council ward the practice was located in had the highest number of reported incidents of domestic abuse between April 2014 and March 2015. We were shown a protocol they had developed where patients would be signposted to helplines and drop-in centres. They would encourage patients to make contact with the helpline whilst in the safety of the building and in an area within the practice would be made available to them to do this from. Mothers attending for their routine eight week baby check would be routinely asked whether they considered themselves at risk from domestic violence.

GPs had identified from the local Children's Services Ofsted report of February 2015 the recommendation GPs, police and midwives should improve their submission of case review reports and attendance at child protection case conferences. This was addressed by the practice manager who would re-schedule the GP's timetables to allow time to write reports and attend child protection conferences for any of their patient's.

Tackling inequity and promoting equality

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients who experienced emotional and well-being issues. Patients had access to telephone interpretation services when needed. Staff at the practice could give us examples of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties. Facilities were on two levels with an accessible lift. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain independence. The walls in the different areas of the practice were painted in different colours to assist patients to find their way around the practice and signs included braille signage. The practice had two hearing loop systems.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Equality and diversity training was provided to staff through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open from 7am to 6pm Monday to Friday. Telephone calls to the practice between 6pm and 6.30pm were answered by the out-of-hours service. GP and practice nurse appointments are available at various times throughout the day from 7am to 5.40pm Monday to Friday with times scheduled to meet predicted demand. Patients contacting the practice for an urgent appointment would speak to the on call GP and an appointment arranged that day if needed. Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to several local care homes on a specific day each week, by the advanced nurse practitioner or the GP and to those patients who requested one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 67% were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 60% described their experience of making an appointment as good compared to the CCG average of 77% and national average of 73%.
- 68% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%.
- 45% said they could get through easily to the surgery by phone compared to the CCG average of 79% and national average of 73%.

Patients we spoke with had mixed experiences with the appointments system. All said it was not easy to get through to the practice by telephone first thing in the morning. They confirmed once they got through a doctor would ring them back if they requested a same day appointment, although this might not be with their GP of choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed patients in urgent need of treatment had often been able to obtain an appointment for the same day of them contacting the practice.

We were told how the practice had identified telephone access to the practice was an issue and were working to improve it. We were shown the data the practice had collected analysing telephone calls to the practice and

Good

Are services responsive to people's needs?

(for example, to feedback?)

requests for appointments and were in discussions with the telephone provider to analyse the data. This information was used to schedule working patterns for the reception team, to meet patient demand.

Appointments were available outside of school hours for children and young people and the premises were suitable for children and young people. Staff at the practice referred young people onto third sector organisations for support with their mental health and well-being and immediate support from youth workers for issues affecting them. One service also provided sexual health and contraceptive information through the C card scheme. The scheme offers free contraception and advice for those young people registered with the service.

Patients we spoke with confirmed the online appointment booking system and prescription request was available and easy to use. Text message appointment reminders were sent to those patients who had registered for the service.

Reception staff told us how they would avoid booking appointments during busy times for people who may find this stressful.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system in the practice leaflet, a poster in reception and on the practice website. Most patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at 28 verbal and written complaints received in the last 12 months. We found some written complaint responses did not contain the investigation process and the outcome of the complaint. We fed this back to the practice manager who told us this had been identified by the management team and further staff training had been identified as a priority for the team who dealt with complaints.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

Staff at Oakwood Lane Medical Practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included the aim to provide high quality care in a caring, courteous and supportive manner.

We spoke with fifteen members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. Staff told us how they had been kept informed of the merger between the two practices and had the opportunity to contribute to the processes by being involved in the specific working groups. For example the design of the premises.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at five of these policies and procedures and most staff had completed a cover sheet to confirm when they had read the policy. All five policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection prevention and control and a partner was the lead for safeguarding. We spoke with fifteen members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Each GP took a lead for an area in the practice and the practice management team took an active leadership role for overseeing the systems in place to monitor the quality of the service were consistently being used and were effective. The included using QOF. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at weekly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, prescribing 'z' drugs. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example an infection prevention and control audit. The practice monitored risks on a monthly basis to identify any areas which needed addressing. Weekly meetings were held for the partners, clinical and management team. We looked at minutes from these meetings and found performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy and the management of sickness which were in place to support staff. We were shown the electronic staff handbook was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

Following the merger of the two practices the partners formed a communication and understanding work stream and sessions were held by external facilitators to enable the newly formed partnership to best use each other's strengths and fill the gaps. This then contributed to the business plan and five year strategy. We were told by staff they were encouraged to identify opportunities to improve the service delivered by the practice. Staff told us the

Are services well-led?

Outstanding ☆

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

partners were visible, approachable and always took the time to listen. We saw from minutes whole practice meetings were held every two months. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at meetings and confident in doing so and felt supported if they did.

An employee assistance programme was available for all staff to access prior, during and after the merger of the two practices. We were told this supported the mental and physical health and well-being of staff during periods of change. Staff told us they could access the service for both work and home related issues and had found the service beneficial.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient forum survey, complaints received and the NHS Friends and Family test. It had an active patient forum which included representatives from some of the population groups. The forum met every six weeks with practice staff representatives and they had a dedicated forum notice board in the waiting area to keep patients informed of their work and also to recruit new members. We were told when the new surgery opened, forum members met and welcomed patients during the first week, explaining the facilities and showing patients round the building. We spoke with six members of the patient forum. They told us how the forum members worked in smaller groups to support the practice in different areas. For example, suggested improvements for the website, reviewing communications to patients and reviewing the practice complaints policy. Some told us the work they had completed had not yet been implemented.

We also spoke with eight practice health champions. They were extremely enthusiastic about the training they had undertaken, supported by the practice, to become a practice health champion. They told us how they were supported by staff in their roles and how the sessions they facilitated had started to make a difference for patients who attended. They provided examples of how the sessions they facilitated had become very popular with patients and people from the local area. They worked in partnership with the local sports centre to deliver chair based exercise sessions and advertised this and other activities in the local community. For example in local shops, on local websites and leisure centres.

We saw evidence the practice had reviewed its' results from the NHS Friends and Family Test to see if there were any areas which needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice through the work of the practice health champions and the patient forum.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

The partners understood the challenges the practice faced in delivering services to the practice population who resided in some of the most deprived and most affluent areas of Leeds. They were innovative in their approach to develop services and new ways of providing care. There was recognition of the need to provide services as close to the patient as possible and practical. This was evidenced by the concept of co-production by the GP and patient health champion group and the introduction of the year of care for patients with long term conditions.

Two GPs had completed the Leeds Institute of Quality Healthcare programme which enabled them to learn with colleagues from the health and social care sector to improve care. We were told how the capacity and demand review of appointments was used by the practice to schedule staff rotas. The CCG also used this data towards predicting the demand for urgent care.

Staff told us their managers supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw regular appraisals took place which included a personal development plan. Managers told us not all staff had received an appraisal since the merger due to leave. We were told reviews would be scheduled when those individuals returned to work.

Are services well-led?

Outstanding ☆

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

The training plan identified the varying levels of training each member of staff was required to undertake and all staff had access to an online training facility. Staff were encouraged to attend the training events held nine times a year when the practice received cover from the CCG. We also learnt staff were given protected time to complete their online training courses.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.