Colton Mill Medical Centre

Inspection report

Stile Hill Way
Colton
Leeds
West Yorkshire
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www.coltonmill-thegrange.nhs.uk

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous rating October 2014 - Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at of Colton Mill and The Grange Medical Centres on 30 October 2018 as part of our inspection programme.

At this inspection we found:

- The practice ensured clinical support arrangements were recorded, these records were documented formally.
- Management of significant events were recorded so that trends could be identified. We saw that the provider recognised and acted on significant events. When incidents did happen, the practice learned from them and improved their processes.
- All patients on high risk medicines had been reviewed in a timely manner and emergency medicines expiry dates were monitored.
- Safeguarding systems had been implemented to ensure relevant information was placed on patients records to alert clinicians when a child was subject to any part of the child protection process.
- A programme of clinical audits had been embedded in the practice to review the effectiveness of care and identify possible areas for improvement.
- The system for dealing with complaints was regularly monitored.
- There were regular clinical and team meetings and processes to improve communication in the practice.
- Patients said they were treated with dignity and trusted the staff.
- The provider had a good relationship with the wider multidisciplinary team members.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided and ensured that care and treatment was delivered according to evidence- based guidelines.
- The leadership team were effective and had a clear vision and purpose. There were systems in place to drive continuous improvement.
- The Patient Participation Group (PPG) engaged with patients during immunisation days and actively supported membership to include people from all backgrounds.
- The practice had developed a Measles outbreak action plan which was shared CCG wide.
- The practice has a dedicated self-check monitoring room which encouraged patient self-management. In the last year 350 patients had used this service. There was an electronic prescribing service for patients who had LTC (88% usage from primary care dashboard report July 18).
- Diabetes nurses were involved in co-producing the first peer review for diabetic foot screening due to high risks in the Leeds area. All nurses were trained on foot screening.
- The practice took part in the national diabetes prevention programme and the referral rates were the highest in Leeds for patients into the programme.
- The practice offered local training events for clinical staff led by lead nurse for respiratory and diabetes.
- The practice implemented the group consultation pilot as one of the locality innovations in Seacroft.
- The practice was the second highest user of 'Leeds care record' for accessing medical records for patients.
- The practice had developed a Measles outbreak action plan which was shared CCG wide.

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

- Review and improve the processes in place for the cleaning and/or replacement of privacy curtains in line with the latest national infection prevention and control guidance.

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

Population group ratings

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

Our inspection team

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

Background to Colton Mill Medical Centre

Colton Mill Medical Centre is registered with CQC to provide primary care services. Regulated activities which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. It provides GP services for patients living in the Colton area of Leeds.

Main Site - Stile Hill Way, Colton, Leeds, West Yorkshire, LS15 9JH.

Branch Site - 999 York Road, Seacroft, Leeds, West Yorkshire, LS14 6NX.

Website: www.coltonmill-thegrange.nhs.uk

A branch surgery 'The Grange Medical Centre' also provides the same services (apart from minor surgery) in the Seacroft area of Leeds and was also visited as part of this inspection. The two sites had a single patient list, so patients could be seen at either site depending on what was more convenient for them.

The practice had five GP partners (three male, two female), two salaried GPs, two associate GPs, a management team, four practice nurses, two healthcare assistants, 16 administrative staff, two senior pharmacists and cleaning staff.

The practice main site was open 8am to 6pm on Monday to Friday; the branch site was open 8am to 8pm on Wednesday and 8am to 8:30pm on Thursday. On a weekend the service was available from 8am to 12pm at alternate locations.

Patients could book appointments in person, via the phone and online.

Appointments could be booked up to a week in advance for the doctors and a month in advance for the nursing clinics. When the practice was closed patients accessed the out of hours NHS 111 service.

The practice was part of NHS Leeds CCG. It was responsible for providing primary care services to 12,909 patients. The female patient population of the practice makes up 51% of the practice population and 21% of all patients are over 60 years of age. The practice was

meeting the needs of an increasingly elderly patient list size that is generally comprised of more women than men.

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

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role and knew how to identify and report concerns. The provider had introduced an alert to inform appropriate staff when there were plans to discuss whether a child was needed to be entered onto the at-risk register.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- There was an effective system to manage infection prevention and control. We noted that not all disposable curtains were changed six monthly, in line with the latest nationally recognised guidance (last changed February 2018). The practice manager told us they would change them straight away as they had an abundant supply in stock.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Staff gave examples of proactive care and treatment for patients with suspected sepsis. 'Signs and symptoms of sepsis' posters were displayed in the practice.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results and all correspondence received at the practice.
- Systems for managing correspondence included scanning all correspondence into the record management system and sending a task alert to the appropriate member of staff.
- The practice introduced a policy that the correspondence box was empty at the end of each day and all correspondence confirmed as 'read'. This new process was monitored.
- Clinicians made referrals which met best practice protocols.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- A system was in place to ensure all medicines were in date and medicines were replaced when required. We noted that children's emergency medicines and medicines for anaphylactic shock were kept separately to enable quick access.

Good

Are services safe?

- Emergency oxygen was situated in an accessible area. Staff had recently received practical training on how to access this equipment.
- We saw that the effectiveness of new systems was discussed at team meetings and audited by the provider.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and acted to support good antimicrobial stewardship in line with local and national guidance.

Track record on safety

- The provider had made improvements in the processes for receiving and responding to national safety alerts. The provider was signed up to receive alerts from many organisations. Relevant alerts were flagged to staff and the action taken in response was recorded. For example, medical record searches were run or the equipment used in the practice was checked and cross referenced.
- The practice monitored and reviewed activity.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- The practice has introduced a walk-in service for appointments Monday to Friday from 8:30am to 9:30am and encouraged online access; the practice had increased online appointment availability.
- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Staff had received additional training in reporting incidents.
- Incidents were recorded on a spreadsheet so the provider had an overview of all incidents reported.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons and looked for themes.
- Action was taken to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

Effective needs assessment, care and treatment

- The practice had introduced systems to ensure clinicians had access to the most recent best practice guidance. The systems included providing direct links to this information via each computer in the consulting rooms. The most recent publications about prescribing medicines was also available in each room.
- We saw that systems were in place to ensure and check whether clinicians employed assessed needs and delivered care and treatment in line with current legislation, standards and guidance. Clinicians were supported by clear clinical pathways and protocols. All the clinicians interviewed demonstrated how they accessed up to date best practice guidance.
- The provider also checked periodically that best practice guidance had been followed.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw that follow-up for patients was timely and supported safe care and treatment.
- We saw no evidence of discrimination when making care and treatment decisions.
- All staff, including receptionists, had been trained to use a recognised pain assessment tool to help determine the appropriate advice, care or treatment to offer patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medicines.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs and had completed dementia awareness training.

People with long-term conditions:

- Patients were encouraged to attend local pulmonary rehabilitation sessions held at the practice and the diabetes expert patient programme (EPP). The EPP is a self-management programme for people who are living with a chronic (long-term) condition.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- There were regular meetings with the community matron to ensure care and treatment was coordinated.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice could demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)

Families, children and young people:

- Childhood immunisation uptake rates were higher than the target percentage of 90%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 77%, which was higher than local and national averages, but lower than the national coverage target of 80%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

Good

Are services effective?

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. Clinicians attended local Gold standard framework (GSF) meetings to ensure patients nearing the end of their lives received well-coordinated care from the practice. The GSF is a national system and programme to enable frontline staff to provide the best possible care for people nearing the end of life.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks and health promotion interventions. Patients were referred for physical activity, obesity, diabetes, heart disease, and access to 'stop smoking' services.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. Front line and clinical staff had completed appropriate dementia care and awareness training.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

A comprehensive programme of quality improvement activity was in place to review the effectiveness and appropriateness of the care provided.

- A series of clinical audits had taken place and repeat audits were planned. Audits that had completed two cycles included the effects of prescribing diabetes medicines.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity.
- Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

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

Coordinating care and treatment

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

- Records showed that appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when

Good

Are services effective?

coordinating healthcare for patients in their home or care homes. The practice conducts two sessions per week offering proactive visits to all six care homes in the area.
- The clinicians also worked with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services or after they were discharged from hospital.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and healthy eating campaigns.

Consent to care and treatment

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

- We saw that all clinicians and a number of administrative staff had completed mental capacity act and deprivation of liberty training.
- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- Records of audits confirmed the practice checked that consent was sought appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results from 2018 were above local and national averages for questions relating to kindness, respect and compassion.
- The practice had also completed their own customer satisfaction survey and the results indicated nearly all patients would recommend the practice to their friends or family.

Involvement in decisions about care and treatment

- Staff helped patients to be involved in decisions about care and treatment. They were aware of and completed training about the Accessible Information Standard (AIS). The AIS is a requirement to make sure that patients and their carers can access and understand the information that they are given.
- Staff communicated with people in a way that they could understand, for example, easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practices GP patient survey results were above local and national averages for questions relating to healthcare professionals listening to the needs and opinion of patients.

Privacy and dignity

The practice respected patients' privacy and dignity.

- There was a privacy zone at the reception area so that patients could provide their details in private. When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs. There were privacy curtains in each consulting room.
- Staff recognised the importance of people's dignity and respect and had completed customer service training.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

- The practice organised and delivered services to meet patients' needs and took account of patient needs and preferences.
- Through working with other local practices, working with the clinical commissioning group (CCG) and taking account of national and local population data, the practice understood the needs of its population and tailored services in response to those needs.
- The facilities and premises were appropriate for the services delivered and a generic risk assessment had been completed by the buildings management company.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice reviewed the appointment system regularly and implemented a walk-in service in 2016 which further changed to meet patient needs. Two GP partners led on rota management to ensure safe cover of GPs. The nurse managers managed the nurse rotas and ensured all clinics were covered with an appropriate skill mix approach.

Older people:

- Elderly patients did not have to attend the surgery for repeat prescriptions and the practice had signed up 39% of its patients for online access and had 65% of patients signed up for ETP (electronic transfer of prescriptions). Telephone medication reviews were available with the pharmacist or home visits if required.
- All patients had a named GP and the practice supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The service provided a daily ward round at the local 'Community Intermediate Care Beds' with weekly support from a consultant geriatrician.
- A weekly ward round was provided with a GP across six care homes in the area.
- A senior nurse practitioner was designated to do home visits and care home visits for patients who were housebound for annual frailty, long term condition reviews and seasonal vaccinations.
- Two senior clinical pharmacists worked each day to deal with care home requests (urgent and routine) with a dedicated care home phone line.
- A GP lead and lead nurse offered end of life (palliative care) support to patients and held a monthly MDT meeting to discuss patients on the register with GPs, nurses, pharmacists, specialist nurses, community nurse and matrons and review care plans.
- The service provided a follow up check with residents in homes who had been discharged from hospital to avoid readmission.
- The service provided urgent and routine home visit reviews with GP's and had implemented a new mobility assessment to identify housebound patients and provided patient information with a home visiting leaflet.
- The service identified patients who had an eFI (electronic frailty index helps identify and predict adverse outcomes for older patients) score of moderately and severely frail and undertook assessments on those patients identified as moderately frail.
- The service provided a domiciliary phlebotomy service to residential homes and housebound patients.
- The provider participated in the CCG bowel cancer screening initiative and had appointed a bowel champion to increase uptake.
- The service had a high uptake of flu vaccinations for over 65's and weekend flu clinics (78% uptake from the July 2018 primary care dashboard report which was above CCG average).
- The service offered a weekly social prescribing clinic staffed by a qualified worker from a local organisation called Connect Leeds.
- The service had an emergency phone line for paramedics, care homes or attached staff to ring to speak to duty doctors in an attempt to avoid admissions.
- Carers were flagged to be seen same day.
- The service engaged with Crossgates and Seacroft good neighbours scheme to support isolated patients and live well Leeds groups.

Good

Are services responsive to people's needs?

- The service offered leg ulcer management and Doppler assessments with current guidance. Lead nurse looked at leg clubs within locality to support isolated patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team and community matron to discuss and manage the needs of patients with complex medical issues.
- The service provided home visits for housebound patients with LTCs.
- The service provided domiciliary phlebotomy service for housebound patients with LTCs.
- There was an electronic prescribing service for patients who had LTC (88% usage from primary care dashboard report July 18).
- Diabetes nurses were involved in co-producing the first peer review for diabetic foot screening due to high risks in the Leeds area. All nurses were trained on foot screening.
- The practice took part in the national diabetes prevention programme and the referral rates were the highest in Leeds for patients into the programme.
- The practice offered local training events for clinical staff led by lead nurse for respiratory and diabetes.
- The practice implemented the group consultation pilot as one of the locality innovations in Seacroft.
- The practice was the second highest user of 'Leeds care record' for accessing medical records for patients.
- Patients with LTC could access the practice 'Healthy Lifestyle Service' which included walking groups, Leeds Rhino partnership men's weight loss programme Jan 18, practice personal trainer and gym, local joint hub exercise services (boxing, circuit, walking football, pilates, chair aerobics, walking groups and 1:1 plans).

Families, children and young people:

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Collaboratively worked with locality practices to offer Saturday GP, nurse and pharmacist appointments in the hub for working age patients.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, referring to doctors at another health centre with extended opening hours and weekend appointments.
- The provider collaboratively worked with locality practices to offer Saturday GP, nurse and pharmacist appointments in the hub for working age patients.

People whose circumstances make them vulnerable:

- The practice had systems in place which could identify patients living in vulnerable circumstances including homeless people and travellers and held a register of people with a learning disability.
- The practice offered a debt management councillor at Christmas time for patients.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. Staff had also completed dementia awareness training.
- The practice signposted patients to clinics and support groups held at the local health centre and other local venues.

Timely access to care and treatment

- Patients could mostly access care and treatment from the practice within an acceptable timescale for their needs.
- The practice fulfilled their contractual obligations and provided above the expected number of appointments.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.

Good

Are services responsive to people's needs?

- Patients with the most urgent needs had their care and treatment prioritised.
- Most patients reported that the appointment system was easy to use.
- The practices GP patient survey results were below the local and national averages for questions relating to access to care and treatment.

Listening and learning from concerns and complaints

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

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

Please refer to the evidence tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

- The practice has a clear leadership structure with a senior GP partner, managing partner and four GP partners. The GP partner was also a director of the GP federation, the managing partner is head of nursing working across the CCG, Leeds community health care and the GP Confederation to drive system integration within nursing teams.
- The senior clinical pharmacist was head of medicines management at the GP federation and had been instrumental in implementing the NHSE clinical pharmacists scheme in Leeds practices.
- The lead nurse was supported in their role as locality lead nurse across Leeds. Two nurses were supported in 2018 to complete a six-month leadership and development programme and quality improvement schemes.
- All services had clinical leads embedded into the practice with non-clinical staff undertaking champion roles.
- The practice has planned for six months for the retirement of the organisation and premises manager and identified new roles within the leadership team and supported training for the senior administrator to develop their role as assistant practice manager from Nov 2018.
- The provider had the skills to deliver high-quality services and we saw improvements in the services provided.
- The provider was knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and had taken steps towards addressing them.
- The provider and managers were visible and approachable.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- Systems were in place to enable the practice to monitor progress against delivery of the strategy.

Culture

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Systems were in place so that leaders and managers could act on performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing junior staff with the development they need. This included appraisal and career development conversations and staff received regular annual appraisals in the last year.
- Staff were supported to meet the requirements of professional revalidation where necessary.
- The provider held a risk register to identify risks in the practice, including risks to staff. The system resulted in the risks being assessed and mitigating action taken.
- The practice actively promoted equality and diversity and staff had received equality and diversity training.
- Staff felt they were treated fairly and there were positive relationships between staff and teams.
- The practice was active in fundraising for charities. In the last 12 months the practice had raised funds for the Yorkshire air ambulance and Prince's Trust.

Governance arrangements

We saw that there were clear responsibilities and roles to support good governance and management. Systems of accountability were also in place.

- Structures, processes and systems to support good governance and management were clearly set out and understood.

Good

Are services well-led?

- The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had in place policies, procedures and activities to promote safety and assure themselves that they were operating as intended.

Managing risks, issues and performance

There were clear processes for managing risks, issues and performance. The provider had introduced processes to identify, understand, monitor and address current and future risks including risks to patient safety.

- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts and incidents.
- Clinical audit had a positive impact on the quality of care and outcomes for patients. There was clear evidence of the action taken to change practice to improve quality.
- The practice had business continuity plans in place and had trained staff in how to respond to major incidents.
- The practice considered and understood the impact on the quality of care when changes were made.
- During a recent flood, the practice had been able to transfer all services to their other site effectively.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to review and improve performance.
- Quality and sustainability were discussed in relevant meetings and all staff had sufficient access to information.
- The practice used internal performance information which was reported and monitored. We noted that staff were usually held to account.
- The information used to support and monitor performance and the delivery of quality care was accurate and useful.
- The practice used information technology systems to monitor and improve the quality of care and submitted data or notifications to external organisations as required.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data.

Engagement with patients, the public, staff and external partners

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

- The views of external partners were sought and acted on to shape services and culture.
- There was an active patient participation group who said they were listened to.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice held a 'Health and Well-being' fair to celebrate the NHS 70th birthday, supported by the PPG. It was attended by local councillors in July 2018 and raised funds for local charities; around 150-200 people attended.
- The practice has access to a health trainer who facilitates exercise activities for patients. External funding had ended but the practice were continuing to self-fund this service.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- In relation to dressings the practice noticed what seemed to be over-requesting of dressings e.g. from nursing homes; some of these were no longer on the formulary. The practice decided on a new approach: they ordered supplies of dressings from NHS supplies, and issued dressings needed to patients, in an attempt to avoid wastage and overuse. The practice was aware they were now using fewer dressings.
- Since the last inspection a new phone system had been installed. This was one system for both sites. The new system enabled management to listen to all phone calls e.g. complaints. The practice could review these calls and used this as a learning tool for staff and for performance management.
- The practice had developed a Measles outbreak action plan which was shared CCG wide.

Good

Are services well-led?

- The practice made use of internal and external reviews of incidents, learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had a strong history of training nurses and doctors who integrated well into the working team. In collaboration with a neighbouring surgery they had become an advanced training practice for nursing students.
- A senior GP at the practice was a GP trainer facilitating the training of doctors.
- The practice manager delivered lectures around nursing in general practice at Manchester University to new student nurses. This maybe would help recruit more nurses into GP practices.
- The practice had secured a city wide AQP (Any Qualified Provider) contract for minor surgery in October 2018. This was a three year contract for patients from other practices in Leeds.

Please refer to the evidence tables for further information.