Lofthouse Surgery

Inspection report

2 Church Farm Close
Lofthouse
Wakefield
West Yorkshire
WF3 3SA

Date of inspection visit: 7 November 2018 to 7 November 2018
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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. The practice was previously inspected in October 2014 when it was rated good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection of Lofthouse Surgery on 7 November 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes. Learning from incidents was shared with others to prevent recurrence.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines. The practice had developed action plans to improve performance when this had been identified as being required.
- Staff involved and treated patients with compassion, kindness, dignity and respect. Patient feedback was positive regarding the treatment they had received.
- Patients generally found the appointment system easy to use, and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. The practice was an early adopter of health improvement programmes, and actively participated in social prescribing.
- Services had been developed to meet the specific needs of their population.
- The practice worked with others at a locality level to plan and develop services.

We saw one area of outstanding practice:

- The practice had developed extensive and dedicated services which supported patients with a learning disability. We saw that these services had delivered effective outcomes for patients and were responsive to their needs. Learning and experiences from their approach to the delivery of these services were openly shared with others to disseminate best practice.

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

- Continue to review and improve performance in relation to diabetes and other long-term conditions where performance has been below local and national levels.

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 a second CQC inspector.

Background to Lofthouse Surgery

Lofthouse Surgery is located at 2 Church Farm Close, Lofthouse, Wakefield, West Yorkshire, WF3 3SA, it also operates a branch surgery The Manse Surgery which is located at 4 Marsh Street, Rothwell, Leeds, West Yorkshire LS26 0AE. The practice provides services for around 10,900 patients under the terms of the General Medical Services contract. The practice building is accessible for those with a disability. In addition, both sites have on-site parking, although the Lofthouse Surgery car parking is limited. There are designated spaces for patients with mobility issues, or those patients who use a wheelchair. It is a member of NHS Leeds Clinical Commissioning Group (CCG).

The practice population catchment area is in an area of lower than average deprivation, being classed as within the seventh most deprived decile in England (with the first decile being the most deprived and the tenth decile being the least deprived). The age profile of the practice shows that it services a higher than average number of older people with 19% of the practice being aged over 65 years as opposed to the CCG average of 15% and a national average of 17%. Average life expectancy for the practice population is 79 years for males and 82 years for females (CCG average is 79 years and 83 years respectively, and the England average is 79 years and 83 years respectively). The practice population identifies as predominantly White British (97%).

Lofthouse Surgery is registered with the Care Quality Commission to provide; diagnostic and screening procedures, family planning, maternity and midwifery services and the treatment of disease, disorder or injury.

The practice offers a range of enhanced local services including those in relation to:

- Childhood vaccination and immunisation
- Influenza and Pneumococcal immunisation
- Dementia support
- Learning disability support

As well as these enhanced services the practice also offers additional services such as those supporting long term conditions management including asthma, chronic obstructive pulmonary disease and diabetes.

Attached to the practice or closely working with the practice is a team of community health professionals that includes health visitors, midwives and members of the district nursing team.

The practice supports the training of student nurses.

The clinical team consists of four GP partners and two other GPs in the process of becoming partners (two male and four female), three practices nurses (all female), three

health care assistants (all female) and one phlebotomist (female). The clinical team is supported by a practice manager and a team of reception and administrative staff.

The practice appointments include:

- Pre-bookable appointments
- Urgent and on the day appointments
- Telephone consultations when required
- Home visits

Appointments can be made in person, via telephone or online.

Telephone lines are staffed until 6:30pm daily and can access the duty doctor up to this time.

When the practice is closed, urgent healthcare advice that is not a 999 emergency is provided by telephoning the local Out of Hours NHS 111 service.

The previously awarded ratings are displayed as required in the practice and on the practice's website.

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. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a 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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. We heard examples from staff when they had raised safeguarding concerns with other bodies.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control and a member of staff had been appointed to lead on this area of work.
- 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. The practice had developed a detailed business continuity plan to support effective service delivery.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Emergency equipment and medicines were regularly checked. However, it was noted that whilst weekly defibrillator checks had been carried out these checks had not been recorded by staff. Since the inspection we have been informed by the practice that they had started to log their regular defibrillor checks.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Reception staff and clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed and audited its antibiotic prescribing and taken action to support good antimicrobial management in line with local and national guidance.
- Prescriptions were generally handled well. However, it was seen that clinicians were not directly informed if a prescription had not been collected by a patient. A note of this non-collection was kept on the patient record. Since the inspection the practice had instituted a new process, whereby non-collected prescriptions were checked on a weekly basis and assessed for potential patient impact by a clinician.

Good

Are services safe?

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- The practice participated in the STOMP LD project (Stopping over medication of people with a learning disability) which aimed to eliminate the over medication of people with a learning disability. As part of the project the practice hosted a pharmacy technician and worked with them to stop the over use of these medicines for patients in the locality.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues. Health and safety risk assessments had been adopted by the practice and implemented. Whilst these covered most areas of operation they had not assessed staff risks in relation to violence to staff and lone working. The practice had later actioned these points and sent us evidence which corroborated this.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements. We saw that the practice discussed incidents in relation to safety at team meetings.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

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

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

Effective needs assessment, care and treatment

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

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions. All staff had received mandatory equality and diversity training.
- The practice used appropriate technology to assess and treat patients. For example, offered opportunistic screening using cardio-respiratory diagnostic devices.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice monitored performance and action planned for future improvement. As examples of this we saw that;
  - Leads had been assigned to improve key performance areas such as work regarding the Quality Outcomes Framework.
  - Action plans had been developed to meet key areas of work.

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 were invited for a health check and/or had a clinical review including a review of medication.
- The practice maintained effective contact with patients who could be at risk. It had reviewed it's records and contacted patients aged over 65 years and who had not been to the practice for five years or over. These patients were offered a health check to assess their needs.
- 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 this included their psychological, mental and communication needs.
- Abdominal aortic aneurysm (AAA) screening was hosted at the practice. We saw that in 2017/18 that 40 patients had attended this screening, and from this one patient with AAA had been detected.
- The practice carried out 2,356 flu vaccinations for those aged over 65 in 2017/18.

People with long-term conditions:

- Patients with long-term conditions had structured annual reviews to check their health and medicines needs were being met. Clinical audit had been used to monitor and improve review performance.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Each doctor and practice nurse had been appointed to lead on a long-term condition and develop actions to improve services and performance.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, members of the nursing team had received additional training with regard to the management of patients with diabetes.
- Adults with newly diagnosed cardiovascular disease were offered statins (work to lower the level of cholesterol in blood) for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)
- The practice's performance on quality indicators for long term conditions was generally in line with or comparable other practices or to local and national averages. However, it was noted that 2017/18 data for diabetes showed the practice to be performing below local CCG and national averages for some areas of care. We discussed this with the practice who told us that they had analysed their diabetes underperformance and had identified that this had been linked to the usage of an incorrect recording template. This had been rectified and an action plan developed to improve

performance. We were later sent unverified data which showed that performance in relation to a number of long-term conditions had improved since April 2018. For example, 64% of patients with diabetes, on the register, had a last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less compared to 59% in 2017/18.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice nursing team saw every child at a new patient registration health check.
- The practice informed health visitors of all new patients aged under 5 years old, and had in place procedures to discuss safeguarding concerns with health visitors when these were identified.

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

- The practice's uptake for cervical screening was 79%, which was slightly below the 80% coverage target for the national screening programme. The performance was though above the CCG average of 74% and national average of 72%. The practice had implemented effective measures to raise participation in the screening programme.
- The practice's uptake for breast and bowel cancer screening was above the national average. The practice had developed a number of measures to improve screening rates. For example, for bowel cancer the practice had:
  - Appointed a bowel cancer champion to promote participation.
  - Sent patients a letter promoting the screening programme with the name of their GP.
  - Discussed with patients' non-participation, and encouraged them to take part.
- The practice had systems to inform eligible patients to have the meningitis vaccine.
- 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:

- The practice had developed extensive and dedicated services which supported patients with a learning disability. Actions and outcomes included:
  - Maintenance of a comprehensive learning disability register. At the time of inspection this identified 56 patients. The records of patients were flagged and alerted those accessing the record for the need to make reasonable adjustments.
  - If a patient was identified with a health issue the practice referral letters clearly stated the needs for reasonable adjustments to facilitate an effective consultation.
  - Social Care Leeds had performed an annual assessment of performance which showed that in 2017/18, 96% of learning disability service users had received a health check. In addition to adult health checks the practice delivered health checks to those aged 14 to 17.
  - The practice actively participated in the STOMP LD project which seeks to stop the inappropriate and unnecessary use on medication on people with a learning disability. As part of this project the practice worked closely with a CCG pharmacist technician (hosted in the practice) and patients received a full medication review and where possible medications were reassessed to enable more effective, less damaging behaviour management programmes. As a result of this activity 37 patients had received a medication review at the time of inspection and 36 of these patients had had their medication changed.
  - The practice had shared it's approach to supporting patients with a learning disability with the local learning disability nursing team, and a GP partner from the practice had visited other local GP providers to meet and share learning with them. This GP partner also acted as the learning disability lead for the local CCG.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice 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):

Good

Are services effective?

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- The practice maintained registers of patients with poor mental health and used these to plan and deliver 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.
- The practices performance on quality indicators for mental health was above local and national averages.

Monitoring care and treatment

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

- Overall exception reporting was below local and nation averages at 4%, compared to CCG and national averages of 6%. However, we saw that some individual conditions such as depression (33%) had higher than local and national averages. We discussed this with the practice who told us that they had systems and processes in place to manage exception reporting and we saw that this was being implemented.
- The practice used information about care and treatment to make improvements and had developed action plans to support service improvement in areas such as diabetes.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

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

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies and care providers.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Good

Are services effective?

Helping patients to live healthier lives

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

- The practice had appointed staff as healthy lifestyle champions to promote opportunities and patient engagement.
- The practice had jointly funded a health trainer to actively advise and assist patients in-house. These were often hard to reach patients who benefitted from specialised support.
- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for the provision of caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results were generally in line with local and national averages for questions relating to kindness, respect and compassion. The practice's own patient survey carried out in January 2018 showed high levels of patient satisfaction. For example, 406 patients either strongly agreed or agreed with the statement that staff at the practice were friendly and approachable compared to two patients who disagreed.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practices GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment. Feedback we received on the day, and information from the practice's own patient survey showed that patients were satisfied with their own involvement in their personal care and treatment, and that clinicians communicated well with them.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.
- Patients told us that they felt well treated and respected by staff, and that the practice was friendly and welcoming.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available on occasions when patients were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, home visits were made to housebound patients to deliver long-term conditions services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. We saw that the practice met regularly with other health and care professionals to discuss vulnerable or complex patients.

Older people:

- This population group was rated as good for providing responsive services.
  All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme. The practice told us that continuity of care was important to them and actively worked to be as flexible as possible to meet the needs of patients to be seen by their regular or preferred clinician.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Care was delivered to over 100 patients in residential care and nursing settings, with visits being made to homes on a weekly basis.
- Patients received regular medication reviews carried out by either a GP or pharmacist.
- Specific health checks were available to those patients aged over 75 years.
- Weekend and evening flu clinics were held to maximise uptake.
- The practice actively supported social prescribing, and were able to refer or signpost patients to activities such as postural stability classes and group walks. This work was supported by a social prescribing counsellor who was hosted at the practice two times a month.
- The practice was in the process of organising a "Lindsay Leg Club" project with other stakeholders. This will be a locality based project where patients attend a community setting to have their dressings changed rather than attend the practice. As well as a physical health service this project looks to improve patient socialisation opportunities and so reduce isolation.
- The practice used text reminders to patients for appointments and clinic attendances.

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 community nursing team to discuss and manage the needs of patients with complex medical issues.
- Nurses made home visits and delivered care to housebound patients with long-term conditions.
- The practice carried out opportunistic screening for long-term conditions when potentially vulnerable patients were identified.

Families, children and young people:

- We found there were systems to identify, follow up and when necessary refer on to safeguarding bodies 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, or had triggered other concerns. Discussions with the practice and records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Good

Are services responsive to people's needs?

- The practice hosted weekly ante-natal clinics delivered by the community midwife. In addition, new mothers and their babies were able to attend a six-weekly health check after delivery.
- A range of contraception and sexual health services were available which included coil fitting.
- Staff had worked with local schools to provide health fairs for pupils and support the development of mental health pathways.

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, the practice offered early morning appointments three days a week, and through working in partnership was able to offer patients GP appointments at another site until 8pm on weekdays, and daytime appointments at weekends.
- Doctors were able to conduct telephone consultations where this was deemed necessary and if patients were unable to attend the practice.
- New patients were offered a dedicated health check delivered by the health care assistant.
- Patients were able to self-refer for physiotherapy support.

People whose circumstances make them vulnerable:

- The practice had developed and delivered a range of responsive services to meet the needs of patients with a learning disability. These included:
  - Patients aged 14 and over were invited to an annual health check and review. A member of the administration team acted as a main point of contact and ensured invitations were made on the telephone and followed up with easy read documentation.
  - Longer appointments were available for patients with a learning disability and others such as the frail elderly with complex needs.
  - Patients that had not attended a health check appointment, or were unable to attend the surgery could arrange for this to be carried out at home.
  - All patients who received a health check were provided with a personal health action plan.
  - Easy read wordage and literature was used in all correspondence, invitations, health questionnaires and information leaflets to aid understanding. A GP partner from the practice worked with other stakeholders to produce free easy read resources which were available on a dedicated website.
  - The GP partner was also involved with other health professionals in producing a Leeds-wide learning disability audit tool. This looked at all aspects of health from health checks to screening and vaccination programmes and could be used to inform future service planning and delivery. The GP had also facilitated and helped to develop two projects which aimed to research ways people with learning disabilities could be assisted to look after their own health with regard to diabetes and by the implementation and adoption of other lifestyle interventions.
  - The practice provided care which included weekly visits to three residential homes for people with a learning disability (25 patients overall). We saw feedback from these homes which praised the practice and the services they received from the GPs.
  - Staff supported patients who had not participated in national screening programmes. We saw how the practice had supported a patient to be accompanied by their carer so they successfully received breast screening.
- Staff had received training to support patients who suffered from domestic abuse and had been accredited as a Domestic Violence Quality Mark Practice.
- The practice had recently applied to the Pride in Practice Pledge, the application demonstrated the practice's commitment and dedication to ensuring a fully inclusive patient-centred service to all patients including those from the LGBT community.
- In addition, the practice had signed up to the Leeds – Commitment to Carers Pledge. This was a commitment to identify and support carers by tailoring services to meet their needs.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice supported patients to access independent mental capacity advocates.
- The practice had audited all patients age 65 years and over who had not been in contact with the practice in the last five years. It had then proactively contacted

Good

Are services responsive to people's needs?

them and invited them to receive a health check. 28 of these potentially vulnerable patients had been identified and had been contacted and three of these patients had taken up the offer of a health check.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was accredited as being dementia friendly and had taken actions to improve services for such patients and their carers.
- The practice hosted a mental health practitioner for half a day per week. The practitioner was able to:
  - Advise clinicians on complex cases.
  - Directly support patients.
  - Refer patients for additional community mental health service support.
  - Access and refer on to crisis support.
- The practice delivered a weekly visit to a local nursing home, some of whose patients had mental health issues.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The practices GP patient survey results were generally in line with local and national averages for questions relating to access to care and treatment. However, it was noted that one indicator whilst comparable to other England practices was significantly below the local average. Only 60% of respondents were satisfied with the type (or types) of appointments offered when compared to a local CCG average of 74%. This data was at odds with feedback from their own patient survey, carried out in January 2018, which showed high overall patient satisfaction with appointments. We however discussed this discrepancy with the practice who said that they would look to examine this further during future patient engagement.

Listening and learning from concerns and complaints

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

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

Please refer to the evidence tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

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

- Senior staff from the practice delivered key roles in both the CCG and local health community.
- The practice had a clear leadership structure, with an experienced management team who understood the needs of their staff and patients.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- The practice shared in-house developments with others, and contributed to the delivery of local projects.

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. For example, the practice had developed a five-year development plan which incorporated their values as well as the identification of key objectives. We saw that this delivery plans had been monitored and that service improvements tracked.
- 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.

Culture

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

- Staff generally stated they felt respected, supported and valued and said they worked well together as a team.
- The practice focused on the needs of patients, and made adjustments to meet the specific needs of patients when this was required.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with development opportunities. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. There was a strong supportive ethos evident within the practice, and we saw that experienced staff mentored staff new to the practice, or those who were developing new skills.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- The practice was open to partnership working and was an early adopter of pilot programmes.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Good

Are services well-led?

- The practice met and discussed issues on a regular basis. We saw that minutes of meetings were kept and were available on the shared IT system.
- Recruitment processes were transparent and personnel records were clear.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks, this included risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints. Staff had been appointed to lead on the delivery of key objectives and areas of performance.
- Action planning was a key feature of service improvement and we saw that these processes were embedded within the practice.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients when developing services and new approaches to care delivery.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group. For example, the practice carried out an extensive in-house patient survey, and had worked closely with local schools to raise and improve awareness of key issues for young people.
- Senior staff engaged with other partners to jointly develop services at locality level.
- The service was transparent, collaborative and open with stakeholders about performance.

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.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had developed an extensive and innovative learning disability service and worked with others to deliver this.
- Senior managers worked with other locality partners to develop and deliver improvements to services.
- The practice shared the knowledge and experiences with other health professionals.

Please refer to the evidence tables for further information.