Dr Yuen Fong Soloman Wong

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Yuen Fong Soloman Wong (known as Ashton View Medical Centre) on 18 May 2016. Overall, the practice is rated as good for providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

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

- The practice complied with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)
- The practice promoted a culture of openness and honesty. All staff were encouraged and supported to record any incidents using the electronic reporting system. There was evidence of good investigation, learning and sharing mechanisms in place.
- Risks to patients were assessed and well managed.
- There were safeguarding systems in place to protect patients and staff from abuse.
- The practice sought patient views how improvements could be made to the service, through the use of patient surveys, the NHS Friends and Family Test and engagement with patients.
- There was a clear leadership structure, staff were aware of their roles and responsibilities and told us the GP and manager were accessible and supportive.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice had good facilities and was equipped to treat and meet the needs of patients.
- Information regarding the services provided by the practice and how to make a complaint was readily available for patients.
- Patients said they found it generally easy to make an appointment, there was continuity of care and urgent appointments were available on the same day as requested. The practice provided a combination of booked appointments and a daily walk-in clinic for patients.
- The practice provided a NHS non-therapeutic (for religious or cultural reasons) circumcision service, for

Summary of findings

male babies up to the age of 12 weeks. Registered patients with all GP practices across the three Leeds Clinical Commissioning Groups had access to the service.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were either comparable or below the national average. This was discussed with the practice and data they had collated for 2015/16 showed improvements.

There was one area where the provider should make improvements:

- Continue to monitor Quality and Outcomes Framework results to improve outcomes for patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- Risks to patients were assessed and well managed
- There were systems in place for reporting and recording significant events and a nominated lead who dealt with them overall. Lessons were shared to ensure action was taken to improve safety in the practice. All staff were encouraged and supported to record any incidents using the electronic reporting system.
- There was a nominated lead for safeguarding children and adults. Systems were in place to keep patients and staff safeguarded from abuse. We saw laminated posters displaying safeguarding information and contact details; which were available for both staff and patients.
- There were processes in place for safe medicines management.
- There were systems in place for checking that equipment was tested, calibrated and fit for purpose.
- There was a nominated lead for infection prevention and control.
- There were processes in place, in line with British Medical Association guidelines, regarding the undertaking of male circumcisions in the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Staff had the skills, knowledge and experience to deliver effective care and treatment. They assessed the need of patients and delivered care in line with current evidence based guidance.
- There was evidence of staff appraisals and personal development plans.
- There was evidence of working with other health and social care professionals, such as the district nursing team, to meet the range and complexity of patients' needs.
- Clinical audits could demonstrate quality improvement.
- End of life care was delivered in a coordinated way.
- Services were provided to support the needs of the practice population, such as screening and vaccination programmes, health promotion and preventative care.

Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were either comparable or below the national average. This was discussed with the practice and data they had collated for 2015/16 showed improvements.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice lower than others for some aspects of care. However, the patient comment cards we received and the practice's own patient survey stated they felt their care was good.
- We observed that staff treated patients with kindness, dignity, respect and compassion. Patients' comments aligned with these observations.
- Information for patients about the services available was easy to understand and accessible. There were leaflets and posters displayed in other languages relevant to the practice population.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice worked with Leeds South and East Clinical Commissioning Group (CCG) and other local practices to review the needs of their population.
- National GP patient survey responses and the majority of comments made by patients showed they found it easy to make an appointment.
- The practice offered pre-bookable, same day and online appointments. They also provided telephone consultations and text message reminders.
- In addition to appointments, there was an 'open' clinic each weekday morning. All patients requiring urgent care were seen on the same day as requested.
- Home visits and longer appointments were available for patients who were deemed to need them, for example housebound patients or those with complex conditions.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was an accessible complaints system. Evidence showed the practice responded quickly to issues raised and learning was shared with staff.

Summary of findings

- The practice provided a NHS non-therapeutic (for religious or cultural reasons) circumcision service, for male babies up to the age of 12 weeks. Patients who were registered with any of the GP practices across the three Leeds Clinical Commissioning Groups had access to the service.

Are services well-led?

Good

The practice is rated as good for being well-led.

- There was a clear leadership structure and a vision and strategy to deliver high quality care and promote good outcomes for patients.
- There were safe and effective governance arrangements in place. These included the identification of risk and policies and systems to minimise risk.
- The provider complied with the requirements of the duty of candour. There were systems in place for reporting notifiable safety incidents and sharing information with staff to ensure appropriate action was taken.
- The practice promoted a culture of openness and honesty. Staff were encouraged to raise concerns, provide feedback or suggest ideas regarding the delivery of services.
- The practice proactively sought feedback from patients through engagement with patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- The practice provided proactive, responsive care to meet the needs of the older people in its population.
- The practice worked closely with other health and social care professionals, such as the district nursing team, to ensure housebound patients received the care and support they needed.
- Care plans were in place for those patients who were considered to have a high risk of an unplanned hospital admission and patients were reviewed as needed.
- Health checks were offered for all patients over the age of 75 who had not seen a clinician in the previous 12 months.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions.

- The GP had lead roles in the management of long term conditions and was supported by the nursing staff. Annual reviews were undertaken to check patients' health care and treatment needs were being met.
- The practice maintained a register of patients who had a high risk of an unplanned hospital admission. Care plans and support were in place for these patients.
- The practice delivered care and support for some patients using an approach called the Year of Care. This approach enabled patients to have a more active part in determining their own needs in partnership with clinicians. It was currently used with patients who had asthma, chronic obstructive pulmonary disease (COPD) or diabetes.
- 50% of newly diagnosed diabetic patients had been referred to a structured education programme in the preceding 12 months (CCG average 87%, national average 90%).
- 68% of patients diagnosed with asthma had received an asthma review in the last 12 months (CCG and national averages of 75%).
- 76% of patients diagnosed with chronic obstructive pulmonary disease (COPD) had received a review in the last 12 months (CCG average 88%, national average 90%).

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- The practice worked with midwives, health visitors and school nurses to support the needs of this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.
- Patients and staff told us children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. All children who required an urgent appointment were seen on the same day as requested.
- Immunisation uptake rates were in line with the CCG and national rates for all standard childhood immunisations.
- Sexual health, contraceptive and cervical screening services were provided at the practice.
- 71% of eligible patients had received cervical screening (CCG and national average 82%).

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice provided an 'open' clinic each weekday morning, telephone consultations, online booking of appointments and ordering of prescriptions.
- The practice offered a range of health promotion and screening that reflected the needs for this age group. This included screening for early detection of COPD (a disease of the lungs) for patients aged 35 and above who were known to be smokers or ex-smokers.
- Health checks were offered to patients aged between 40 and 74 who did not have a pre-existing condition.
- Travel health advice and vaccinations were available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Summary of findings

- Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- We saw there was information available on how patients could access various local support groups and voluntary organisations.
- As part of the blood borne virus screening programme, HIV, Hepatitis B and Heptatis C testing were offered to all new patients aged between 16 and 65. Testing was also offered to those patients who were thought to be 'at risk'. Ashton View Medical Centre, as a general practice, had the highest numbers of screening uptake rates across the whole of Leeds.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice regularly worked with multidisciplinary teams, such as the local mental health team, in the case management of people in this population group.
- Patients and/or their carer were given information on how to access various support groups and voluntary organisations.
- There was evidence that some patients who had dementia or a complex mental health problem, such as schizophrenia, bipolar affective disorder and other psychoses, had received a review of their care in the preceding 12 months.
- Patients who were at risk of developing dementia were screened and support provided as necessary.
- Staff had a good understanding of how to support patients with mental health needs or dementia.

Summary of findings

What people who use the service say

The national GP patient survey distributed 396 survey forms of which 62 were returned. This was a response rate of 16% which represented less than 2% of the practice patient list. The low return rate could be attributed to the high numbers of patients who were of non-English origin. The results published in January 2016 showed the practice was performing in line with local CCG and national averages, for the majority of questions. For example:

- 86% of respondents described their overall experience of the practice as fairly or very good (CCG 82%, national 85%)
- 66% of respondents said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG 76%, national 79%)
- 75% of respondents described their experience of making an appointment as good (CCG 70%, national 73%)
- 86% of respondents said they found the receptionists at the practice helpful (CCG 85%, national 87%)
- 78% of respondents said they had confidence and trust in the last GP they saw or spoke to (CCG 94% and national 95%)
- 96% of respondents said they had confidence and trust in the last nurse they saw or spoke to (CCG 96%, national 97%)

As part of the inspection process we asked for CQC comment cards to be completed by patients. We received 8 comment cards all, with the exception of one, were positive and used the words 'excellent' and 'first class' to describe the service and care they had received. They also cited staff as being caring, helpful and professional.

Unfortunately, the inspection team were unable to speak with patients on the day of the inspection due to language barriers. However, we did note that staff respectfully spoke to patients and told us they overcame any barriers in communication by speaking in their own language or using interpretation services.

Areas for improvement

Action the service SHOULD take to improve

There was one area where the provider should make improvements:

- Continue to monitor Quality and Outcomes Framework results to improve outcomes for patients.

Dr Yuen Fong Soloman Wong

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team comprised of a CQC inspector and a GP specialist advisor.

Background to Dr Yuen Fong Soloman Wong

Dr Yuen Fong Soloman Wong is a member of the Leeds South and East Clinical Commissioning Group (CCG). General Medical Services (GMS) are provided under a contract with NHS England. The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: maternity and midwifery services, diagnostic and screening procedures and treatment of disease, disorder or injury. They also offer a range of enhanced services, which include delivering childhood, influenza and pneumococcal vaccinations.

Dr Wong provided a NHS non-therapeutic (for religious or cultural reasons) circumcision service, for male babies up to the age of 12 weeks. Registered patients with all GP practices across the three Leeds Clinical Commissioning Groups had access to the service. The circumcision service was provided in accordance with best practice guidance from the British Medical Association (BMA).

Ashton View Medical Centre is located in an area of high deprivation within the Harehills district, being in close proximity to Leeds city cente and St James Hospital. The practice is situated in purpose built premises, which are rented. There are three consulting rooms and two treatments rooms; one of which is used for minor surgery procedures. There is disabled access and car parking facilities on site at both the front and back of the building. There is also wifi available for staff and patient usage.

The practice has a patient list size of 3,620, with a less than 8% being white British. It has a very multicultural population with over 40 different languages being spoken by registered patients. The practice has an average number of 50 patients per month who register or leave, due to the migratory culture of some patients. There are interpretation and translation facilities available and many of the staff are multilingual. The practice has a higher than CCG and national average number of patients aged 45 years and under; with over a quarter of the practice list aged 0 to 15 years. At 4%, the numbers of patients aged 65 years and above are considerably lower than CCG and national averages, being 15% and 17% respectively. On average, over 30% of patients on the practice list are unemployed, compared to CCG and national averages of 8% and 5% respectively.

Ashton View Medical Centre is a single handed male GP led practice, which employs a male salaried GP. Other clinical staff consist of a practice nurse, a health care assistant and a phlebotomist; all of whom are female. There is a practice manager and a team of administration and reception staff who oversee the day to day running of the practice. At the time of our inspection the salaried GP was on a sabbatical and a regular female locum GP was working at the practice.

The practice is open between 8am to 6pm Monday to Friday. GP appointments are available:

Monday to Friday 9am to 10.30am

Monday and Thursday 4pm to 5.30pm

Tuesday, Wednesday and Friday 3pm to 5.30pm

Detailed findings

In addition there are 'open' clinics from 8.15am to 9am each weekday.

When the practice is closed out-of-hours services are provided by Local Care Direct, which can be accessed via the surgery telephone number or by calling the NHS 111 service.

The practice has good working relationships with local health, social and third sector services to support provision of care for its patients. (The third sector includes a very diverse range of organisations including voluntary, community, tenants' and residents' groups.)

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions and inspection programme. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations, such as NHS England and Leeds South and East CCG, to share what they knew about the practice. We reviewed the latest 2014/15 data from the Quality and Outcomes Framework (QOF) and the latest national GP patient survey results (January 2016). (QOF is a voluntary incentive scheme for GP practices in the UK, which financially rewards practices for the management of some of the most common long term conditions.) We also reviewed policies, procedures and other relevant information the practice provided before and during the day of inspection.

We carried out an announced inspection on 18 May 2016. During our visit we:

- Spoke with a range of staff, which included the lead GP, the practice nurse, the practice manager and the phlebotomist/administrator.
- Reviewed comment cards where patients and members of the public shared their views.
- Observed in the reception area how patients, carers and family members were treated.
- Looked at templates and information the practice used to deliver patient care and treatment plans.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a comprehensive system in place for reporting, recording and investigating significant events.

- There was a culture of openness, transparency and honesty. Staff told us they would inform the practice manager of any incidents and complete the electronic incident recording form.
- The practice was aware of their wider duty to report incidents to external bodies such as Leeds South and East CCG and NHS England. This included the recording and reporting of notifiable incidents under the duty of candour.
- When there were unintended or unexpected safety incidents, we were informed patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We saw evidence the practice carried out a thorough analysis of significant events. We were informed of examples where there had been learning and actions had been taken, for example in the case of a safeguarding incident.
- All significant events relating to medicines were monitored by the local CCG medicines management team. Any concerns or issues were then fed back to the practice to act upon.
- There was an effective system in place to ensure all safety alerts were cascaded to staff and actioned as appropriate.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse. We saw evidence of:

- Arrangements which reflected relevant legislation and local requirements were in place to safeguard children and vulnerable adults from abuse. Policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. There were laminated posters displaying safeguarding information and contact details in all the consulting and treatment rooms and in the reception area. Staff had received training relevant to their role and could demonstrate their understanding of safeguarding. The GP acted in the capacity of safeguarding lead and had been trained to the appropriate level three. We were informed that although the health visitor did not regularly attend the practice they ensured any safeguarding issues or concerns were communicated to them.
- A notice was displayed in the waiting room, advising patients that a chaperone was available if required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS). (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.) It was recorded in the patient's records when a chaperone had been in attendance.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We saw up to date cleaning schedules in place. There was a nominated infection prevention and control (IPC) lead and an IPC protocol in place. All staff were up to date with IPC training. We saw evidence that an IPC audit had taken place and action had been taken to address any improvements identified as a result.
- There were processes in place in line with British Medical Association (BMA) guidelines regarding the undertaking of non-therapeutic (for religious or cultural reasons) circumcisions in the practice. BMA good practice guidelines state that "usually and where applicable both parents must give consent for non-therapeutic circumcision". We saw a consent form, information about the procedure, aftercare guidelines and a patient feedback form. General Medical Council and the British Association of Paediatric Surgeons guidance states "that when undertaking circumcision doctors must use appropriate measures including anaesthesia to minimise pain and discomfort". We were informed of the anaesthesia used in all cases and the post-operative pain relief which was prescribed.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Regular medication audits were carried out

with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads and blank prescriptions were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs), in line with legislation, had been adopted by the practice to allow nurses to administer medicines. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).

- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment, in line with the practice recruitment policy, for example proof of identification, references and DBS checks.

Monitoring risks to patients

The practice had procedures in place for assessing, monitoring and managing risks to patient and staff safety. We saw evidence of:

- Risk assessments to monitor the safety of the premises, such as the control of substances hazardous to health and legionella (legionella is a term for a bacterium which can contaminate water systems in buildings).
- A health and safety policy and up to date fire risk assessment.
- All electrical and clinical equipment was regularly tested and calibrated to ensure the equipment was safe to use and in good working order.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff worked flexibly to cover any changes in demand, for example annual leave, sickness or seasonal.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. We saw:

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff were up to date with fire and basic life support training.
- There was a fire evacuation plan in place which identified how staff could support patients with mobility problems to vacate the building. Regular fire drills were carried out and staff were aware of their responsibilities
- There was emergency equipment available, which included a defibrillator and oxygen.
- Emergency medicines were stored in a secure area which was easily accessible for staff. All the medicines and equipment we checked were in date and fit for use.
- The practice had an effective accident/incident recording and reporting system in place.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and was available on the practice intranet and as a paper copy.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). We saw minutes from meetings which could evidence QOF was discussed within the practice and any areas for action were identified.

The most recent published results (2014/15) showed the practice had achieved 72% of the total number of points available, with 10% exception reporting. This was in line with the CCG and national average of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data showed:

- Performance for some diabetes related indicators was lower than the CCG and national averages. For example, 75% of patients on the diabetes register had a recorded foot examination completed in the preceding 12 months, compared to the CCG and England averages of 88%.
- Performance for mental health related indicators was lower than the CCG and national averages. For example, 57% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of blood pressure in the preceding 12 months, compared to the CCG average 88% and England average 90%.

We discussed the issues regarding the lower than CCG and national average figures for some QOF domains. The practice informed us how they monitored QOF; they were proactive in inviting patients, chasing up non-attenders and undertaking opportunistic screening. However, due to the migratory nature and culture of many patients this had caused some issues in the recalling and reviewing of patients. It was felt the practice was not using exception reporting in all appropriate instances. The practice had recently employed a member of staff to look at the recall systems, non-attenders and reporting to identify key areas for improvement. We reviewed a report which showed there had been improvements in the QOF data for 2015/16 (which had not yet been formally submitted). For example, there had been no 2014/15 data regarding indicators for dementia. The current 2015/16 data evidenced the practice had reviewed 67% of patients who had a diagnosis of dementia.

The practice used clinical audit, peer review, local and national benchmarking to improve quality. They also participated in local audits, for example antibiotic prescribing. We reviewed two audits, one on the management of exacerbations of chronic obstructive pulmonary disease and the other relating to the improvement of dementia detection. Both these audits could demonstrate improvements and further actions.

We were also shown the review the GP had undertaken of any post-operative complications for patients who had undergone circumcision. There had been 17 minor complications in three years (this equated to approximately 1% of patients).

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Evidence we reviewed showed:

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.
- Staff had received mandatory training that included safeguarding, fire procedures, infection prevention and control, basic life support and information governance

awareness. The practice had an induction programme for newly appointed staff which also covered those topics. Staff had access to and made use of e-learning training modules and in-house training.

- The practice supported learning and development of staff, for example the phlebotomist/administrator was commencing health care assistant training in July of this year.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. They kept up to date with changes to the immunisation programmes, by using online resources and having discussions with other clinicians
- The GP was up to date with their revalidation and appraisal.

Coordinating patient care and information sharing

The practice had timely access to information needed, such as medical records, investigation and test results, to plan and deliver care and treatment for patients. They could evidence how they followed up patients who had an unplanned hospital admission or had attended accident and emergency (A&E); particularly children or those who were deemed to be vulnerable. We were informed that all patients who presented at A&E on more than one occasion were reviewed and discussed, to identify if there were any areas of concern.

Staff worked with other health and social care services to understand and meet the complexity of patients' needs and to assess and plan ongoing care and treatment. Information was shared between services, with the patient's consent, using a shared care record. We saw evidence that multidisciplinary team meetings took place on a monthly basis, to discuss patients and clinical issues.

Care plans were in place for those patients who had complex needs, were at a high risk of an unplanned hospital admission or had palliative care needs. These were reviewed and updated as needed. Information regarding end of life care was shared with out-of-hours services, to minimise any distress to the patient and/or family.

Consent to care and treatment

Staff understood the relevant consent and decision-making requirements of legislation and guidance, such as the Mental Capacity Act 2005. Patients' consent to care and treatment was sought in line with these. Where a patient's mental capacity to provide consent was unclear, the GP or nurse assessed this and, where appropriate, recorded the outcome of the assessment.

When providing care and treatment for children 16 years or younger, assessments of capacity to consent were also carried out in line with relevant guidance, such as Gillick competency and Fraser guidelines. These are used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted those to relevant services. These included patients:

- who were in the last 12 months of their lives
- at risk of developing a long term condition
- required healthy lifestyle advice, such as dietary, smoking and alcohol cessation
- who acted in the capacity of a carer and may have required additional support

We were informed, and saw evidence in some instances, that Ashton View Medical Centre:

- Encouraged patients to attend national screening programmes for cervical, bowel and breast cancer. A member of staff was a nominated bowel screening champion.
- Had failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. Patients were contacted and reminders were sent out to those eligible for cervical screening. The uptake rate for cervical screening in the preceding five years was 71%, compared to the CCG and England averages of 82%.
- Carried out immunisations in line with the childhood vaccination programme. Uptake rates were comparable to the national averages. For example, children aged up to 24 months ranged from 88% to 94% and for five year olds they ranged from 81% to 96%.
- The practice had acknowledged the lower than average figures and had recently employed the services of a locum practice nurse to specifically carry out cervical screening and childhood immunisations.

Good

Are services effective?

(for example, treatment is effective)

- Patients had access to appropriate health assessments and checks. These included NHS health checks for people aged 40 to 75. Where abnormalities or risk factors were identified, appropriate follow-ups were undertaken.
- The practice screened patients aged 35 and above who were known to be smokers or ex-smokers, for the early detection of chronic obstructive pulmonary disease (a disease of the lungs).
- The practice offered blood borne virus testing for HIV, Hepatitis B and Hepatitis C, for all new patients aged between 16 and 65 and those patients who were 'at risk'. Ashton View Medical Centre was the highest screening practice in Leeds.
- Health trainers attended the practice two days a week to provide additional support for patients with lifestyle advice and weight loss.
- Had recently met with the Leeds Connect for Health service with a view to facilitating sessions to provide additional support, particularly around social needs, for patients.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that:

- Members of staff were courteous and helpful to patients and treated them with dignity and respect.
- There was a private room should patients in the reception area want to discuss sensitive issues or appeared distressed.
- Curtains were provided in consulting and treatment rooms to maintain the patient's dignity during examinations, investigations and treatment.
- Doors to consulting and treatment rooms were closed during patient consultations and that we could not hear any conversations that may have been taking place.
- Chaperones were available for those patients who requested one and it was recorded in the patient's record.

Data from the national GP patient survey showed respondents rated the practice lower than the CCG and national average for many questions regarding how they were treated. For example:

- 65% of respondents said the last GP they saw or spoke to was good at listening to them (CCG 87%, national 89%)
- 57% of respondents said the last GP they saw or spoke to was good at giving them enough time (CCG 85%, national 87%)
- 58% of respondents said the last GP they spoke to was good at treating them with care and concern (CCG 82%, national 85%)
- 92% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG and national 91%)
- 91% of respondents said the last nurse they saw or spoke to was good at giving them enough time (CCG and national 92%)
- 78% of respondents said the last nurse they spoke to was good at treating them with care and concern (CCG 90%, national 91%)

The February 2016 practice patient survey of 46 patients, did not align with some of the responses from the national survey. For example, during a GP consultation 93% of patients said they felt listened to, had enough time and were treated with care and concern.

Seven out of the eight Care Quality Commission patient comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

Care planning and involvement in decisions about care and treatment

The practice provided facilities to help patients be involved in decisions about their care:

- The choose and book service was used with all patients as appropriate.
- Interpretation and translation services were available for patients who did not have English as a first language. Many of the staff were multilingual.
- There were information leaflets and posters displayed in the reception area available for patients; many in languages suitable for the practice population.

The Year of Care model was used with patients who had diabetes, chronic obstructive pulmonary disease (a disease of the lungs) or coronary heart disease. This approach enabled patients to have a more active part in determining their own care and support needs in partnership with clinicians. Individualised care plans for these patients were maintained.

Data from the national GP patient survey showed respondents rated the practice lower than other local and national practices. For example:

- 59% of respondents said the last GP they saw was good at involving them in decisions about their care (CCG 80%, national 82%)
- 63% of respondents said the last GP they saw was good at explaining tests and treatments (CCG 84%, national 86%)
- 77% of respondents said the last nurse they saw was good at involving them in decisions about their care (CCG 84%, national 85%)
- 86% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG 89%, national 90%)

Again, the practice patient survey did not align with some of the responses from the national survey. For example,

Good

Are services caring?

93% of patients said that during a GP consultation they were involved in decisions about their care and 87% said tests and treatments were explained to them (in 4% it did not apply).

Patient and carer support to cope emotionally with care and treatment

The patient electronic record system alerted clinicians if a patient was also a carer. The practice maintained a carers' register and offered additional support as needed. Carers were signposted to access further support as needed. We saw there was a notice board in the reception area with various information suitable for carers.

The practice worked jointly with palliative care and district nursing teams to ensure patients who required palliative care, and their families, were supported as needed. We were informed that if a patient had experienced a recent bereavement, they would be contacted and support offered as needed.

We saw there were notices and leaflets in the patient waiting area, informing patients how to access a number of support groups and organisations. There was also information available on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with NHS England and Leeds South and East CCG to review the needs of its local population and to secure improvements to services were these were identified. These included:

- Home visits for patients who could not physically access the practice and were in need of medical attention
- Urgent access appointments for children and patients who were in need
- Telephone consultations
- Longer appointments as needed
- Travel vaccinations which were available on the NHS
- Disabled facilities
- Interpretation and translation services
- Provision of a NHS non-therapeutic circumcision service, for male babies up to the age of 12 weeks. Patients who were registered with any of the GP practices across the three Leeds Clinical Commissioning Groups had access to the service.

Access to the service

The practice was open between 8am to 6pm Monday to Friday. GP appointments were available:

Monday to Friday 9am to 10.30am

Monday and Thursday 4pm to 5.30pm

Tuesday, Wednesday and Friday 3pm to 5.30pm

In addition there were 'open' clinics from 8.15am to 9am each weekday

Appointments could be booked in advance and same day appointments were available for people that needed them.

When the practice was closed out-of-hours services were provided by Local Care Direct, which could be accessed via the surgery telephone number or by calling the NHS 111 service.

Data from the national GP patient survey showed respondents rated the practice comparable to other local and national practices. For example:

- 76% of respondents were fairly or very satisfied with the practice opening hours (CCG 77%, national 78%)
- 76% of respondents said they could get through easily to the surgery by phone (CCG 68%, national 73%)
- 86% of respondents said the last appointment they got was convenient (CCG 91%, national 92%)

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- The practice kept a record of all written and verbal complaints.
- All complaints and concerns were discussed at the practice meeting.
- There was information displayed in the waiting area to help patients understand the complaints system.

There had been six complaints received in the last 12 months. We found they had been satisfactorily handled. Lessons had been learned and action taken to improve quality of care.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality, safe and effective care in response to patient needs. There was a statement of purpose submitted to the Care Quality Commission which identified the practice values, for example "to improve the health and well-being of patients".

Although the national patient survey satisfaction scores and QOF data were below the CCG and national averages in some instances, the practice had a clear view of what it wanted to improve in the coming year. This had been discussed with staff and there was a genuine enthusiasm to improve as a whole and ensure good outcomes for patients.

Governance arrangements

The practice had good governance processes in place which supported the delivery of good quality care and safety to patients. This ensured there was:

- A good understanding of staff roles and responsibilities. Staff had lead key areas, such as safeguarding, dealing with complaints and significant events, data and recall of patients, and infection prevention and control.
- Practice specific policies were implemented, updated, regularly reviewed and available to all staff.
- A comprehensive understanding of practice performance. Practice meetings were held where practice performance, significant events and complaints were discussed.
- A programme of clinical audit used to monitor quality and drive improvements.
- Robust arrangements for identifying, recording and managing risks.
- Business continuity and comprehensive succession planning in place, for example the upskilling of staff.
- A 'buddying' system with two other local practices, should there be an emergency, loss of computer systems or use of the premises.

Leadership and culture

The practice was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There was a culture of openness and honesty. We were informed that when there were unexpected or unintended incidents regarding care and treatment, the patients affected were given reasonable support, truthful information and a verbal and written apology.

On the day of the inspection the GP and practice manager could demonstrate they had the experience, capacity and capability to run the practice.

- There was a clear leadership structure.
- We were informed that the GP and practice manager were visible, approachable and took the time to listen.
- Staff informed us they felt respected, valued and supported.
- We saw evidence of meetings being held within the practice, such as nursing and administration
- The practice minuted a range of multidisciplinary meetings they held with other health and social care professionals to discuss patient care and complex cases, such as palliative care.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through day to day engagement with them. We were informed there had been a patient participation group (PPG) but this had recently ceased due to non-attendance. We saw there was a notice board in the reception area displaying details of the PPG and other information for patients. There were plans to reinstigate the PPG and the practice were looking at different methods, such as the possibility of a virtual group.
- The NHS Friend and Family Test, complaints and compliments received.
- Staff through meetings, discussions and the appraisal process. Staff told us they would not hesitate to raise any concerns and felt involved and engaged within the practice to improve service delivery and outcomes for patients.

Continuous improvement

Are services well-led?

Good

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

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local and national schemes to improve outcomes for patients in the area. For example:

- They had recently joined a federation of practices within the CCG, to look at how the delivery of primary care services could be improved within the local area.
- The practice had recently received training in preparation for becoming a collection point for the C-Card Scheme; which supported young people under the age of 25 access to free condoms.