Ashfield Medical Centre

Quality Report

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Date of inspection visit: 14 October 2014
Date of publication: 08/01/2015

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 inspected Ashfield Medical Centre on the 14th and 15th October 2014 as part of our new comprehensive inspection programme.

We have rated the practice as good. Patients were complimentary about the staff and the care and treatment they received.

Our key findings were as follows:

- Patients could usually get an appointment but they sometimes had difficulty contacting the practice by telephone.
- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement.
- Patients were treated with courtesy and respect and involved in their diagnosis and treatment.
- The practice sought and acted upon feedback from staff and patients.

We saw areas of outstanding practice including:-

- The practice had adopted the 'Year of Care' approach for patients with COPD. The practice had provided patients with additional information, including a copy of their care plan and their test results. This encouraged patients to be more proactive about their condition and aware of when to seek help.
- A staff 'Recognition Scheme' had been introduced to acknowledge outstanding behaviour or performance.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for effective. Our findings at inspection showed systems were in place to ensure that all clinicians were not only up-to-date with both NICE guidelines and other locally agreed guidelines. We also saw evidence that these guidelines were influencing and improving practice and outcomes for their patients. We saw data that showed that the practice is performing highly when compared to neighbouring practices in the CCG. The practice is using innovative and proactive methods to improve patient outcomes and it links with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy and staff were clear about their responsibilities in relation to this. There was a clear leadership structure and staff felt

Summary of findings

supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported Quality Outcome (QOF) data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of services, for example, in dementia and end of life care.

People with long term conditions

Outstanding

The practice is rated as outstanding for the population group of people with long term conditions

The practice had adopted the 'Year of Care' approach for patients with COPD. Patients were provided with additional information about their condition, including a copy of their care plan and their test results. This encouraged patients to be more proactive in managing their condition and aware of when to seek help.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. There were close working arrangements with the midwives and health visitors to deliver ante and post natal care. Six-week post natal and baby checks were carried out at the same appointment. Systems were in place for identifying and following-up children who were at risk.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population had been identified and the practice had adjusted the availability of appointments to increase flexibility for working adults. The practice offered text messaging of results and on-line booking of appointments and requests for repeat prescriptions

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and was proactive in offering them an annual health check and longer appointment

Summary of findings

times. Nationally reported Quality Outcome (QOF) data showed that 100% of these patients had attended for their annual check. Staff knew how to recognise signs of abuse and were aware of their responsibilities regarding reporting safeguarding concerns.	
People experiencing poor mental health (including people with dementia) The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). There were screening and diagnostic pathways to assess patients for dementia. Patients at high risk or those with chronic diseases were screened for signs of depression. The reception staff were alert to signs which may indicate a person was experiencing a mental health problem or behaving uncharacteristically and may need additional support or urgent attention.	Good 

Summary of findings

What people who use the service say

During our visit we spoke with seven patients and received 29 completed CQC comment cards. Patients were very complimentary about the staff and the care and treatment they received. They felt they were treated with courtesy and respect and involved in their diagnosis and treatment. They told us they could usually get an appointment at one of the practices' two surgeries but that they often had difficulty contacting the practice by telephone. These views were supported by the findings of the practice's own Patient Participation Group and the National General Practice Survey.

Outstanding practice

- The practice had adopted the 'Year of Care' approach for patients with COPD. The practice had provided patients with additional information, including a copy of their care plan and their test results. This encouraged patients to be more proactive about their condition and aware of when to seek help.
- A staff 'Recognition Scheme' had been introduced to acknowledge outstanding behaviour or performance.

Ashfield Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a General Practitioner and a Specialist Advisor with experience of working as a practice manager.

Background to Ashfield Medical Centre

Ashfield Medical Centre, also known as Dr Eastwood and Partners, is a GP training practice located across two sites in the Crossgates and Seacroft areas of Leeds. As part of our inspection we visited both sites.

The practice provides primary care services, under the terms of a Personal Medical Services contract, for approximately 6,400 patients. There are four permanent doctors and one salaried doctor at the practice. They are supported by three practice nurses, two healthcare assistants and an experienced administrative team. The practice is registered with the CQC to provide the following regulated activities:-

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

The practice list is open to new patients living in the practice area. The practice is open each weekday and offers extended services from 7am on Tuesdays and Thursdays. Regular clinics are available providing advice and treatment for; cervical screening, contraception, joint injection, chronic disease management health promotion and smoking cessation. Patients can book an appointment in person at either of the surgeries, by telephone or on-line. The practice does not open at weekends. Out of hours care is provided by the Local Care Direct.

Approximately 20% of patients registered with the practice are aged under 18 years. Patients aged over 65 years account for approximately 19% of the registered practice population. These percentages are similar to the average for all GP practices in England. Income deprivation indices affecting children and older people are both similar to England averages.

The results of the National Patient Survey 2014 for the practice indicate that 98% of the patients who replied said the last GP they saw or spoke to was good at listening to them. A similar number (92%) said the last GP they saw or spoke to was good at treating them with care and concern and 85% of respondents would recommend this surgery to someone new to the area. These results are better than the average for other GP practices in the area.

In answer to other questions 58% said it was easy to get through to this surgery by phone , 64% of describe their experience of making an appointment as good and 54% usually got to see or speak to their preferred GP. These results are lower than those for other GP practices in the area.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This provider had not been inspected before and this inspection was planned to check

Detailed findings

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.

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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 and 15 October 2014. During our visit we spoke with a range of staff (doctors, nurses, receptionists and managers) and spoke with patients who used the service. We reviewed comment cards where patients shared their views and experiences of the service.'

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

Systems were in place to monitor and assess the safety of the services provided to patients and to support the delivery of good clinical care. Risks to good patient care were identified and used to improve the quality of the service. Patient safety was monitored using information from a range of sources. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records, incident reports and the minutes of practice meetings where these were discussed. The practice participated in local peer review arrangements, for example for all new cancer diagnoses, and shared learning within the staff clinical team and the CCG. Monitoring of patients prescribed 'amber drugs' (drugs administered under the shared care of a hospital consultant and the patient's GP) were comprehensive and supported by regular quarterly audits

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant incidents, including near misses**.** Staff, including receptionists, administrators and nursing staff were aware of the system for raising issues and were encouraged to do so. Incident reporting forms were available on the practice intranet. Completed forms were reviewed by the duty doctor and sent to the appropriate member of the clinical team for investigation, action and reporting. Incidents requiring urgent action were dealt with without delay and corrective measures put in place. All new significant incidents were considered at the following weekly Monday morning clinical team meeting. Follow-up reviews and assessment of the effectiveness of any corrective actions were considered at bi-monthly practice training (TARGET) meetings.

Details of significant incidents that had occurred during the previous 12 months (October 2013 to September 2014) were made available to us. We tracked two incidents and saw records were completed in a comprehensive and timely manner and the action taken as a result. A similar system was in place to monitor patient complaints. However this was limited to written complaints and the practice may find it useful to also record and log concerns made verbally.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff told us they had undertaken role specific training in the safeguarding of children and adults. This included Level 3 training as currently recommended for general practitioners.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding reporting and documenting safeguarding concerns and how to contact the relevant agencies. Safeguarding contact details of other local health and social care services were displayed in the consulting rooms, treatment rooms and by the reception desk.

Safeguarding issues and concerns about specific patients were discussed with health visitors, district nurses and social workers during bi-monthly practice meetings The practice received updates from the local social services department on any serious cases and the doctors attended safeguarding case conference when possible.

There was a system to highlight vulnerable patients on the practice's electronic records, including children on the child protection register. This ensured staff were aware of any relevant issues when patients attended appointments. Staff were also aware of the importance of being vigilant, both when patients attended the practice and when speaking to patients, family members or carers by telephone. For example, we were told of an incident where a member of staff had raised a concern about a vulnerable adult as a result of background noises heard whilst a relative was telephoning the practice. In another case a receptionist reported concerns about a patient who appeared confused and was behaving uncharacteristically.

A chaperone policy was in place and prominently displayed on the waiting room noticeboard and in the consulting rooms. Chaperone training had been undertaken by all nursing staff. If nursing staff were not available to act as a

chaperone receptionists were asked to act as chaperones. They had received training from the Lead Nurse and understood their responsibilities including when and where to stand so as to maintain the patient's dignity.

Medicines Management

Systems were in place to check that sufficient stocks of emergency medicines, including those kept in doctor's bags, were available, within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with the relevant waste disposal regulations.

Protocols were in place for the ordering, storing and handling of vaccines. The practice nurses, healthcare assistants and receptionists had undergone training on the handling of vaccines and how to report any failures. Vaccines were securely stored ready for use in temperature monitored medicine refrigerators. Daily records were kept of the internal temperature and the minimum and maximum temperature over the previous 24 hours. Instructions on the safe storage of medicines were displayed on the refrigerator doors and included actions to be taken in the event of a cold chain failure.

Patients issued with repeat prescriptions were reviewed at least once a year as a minimum. Those deemed as a higher risk were review more frequently. Prescribing limits were applied for contraceptives, hormone replacement therapy, controlled drugs and certain analgesics or where a concern had been identified. Amber or shared care drugs were monitored in line with a locally initiated CCG scheme and audited quarterly with support from the local medicines management team. A pharmacist visited the practice each week to carry out medication audits, cost effectiveness reviews and where appropriate made suggestions for the prescribing of alternative more cost effective medication.

Cleanliness & Infection Control

Patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control. Both the Ashfield Medical Centre and The Grange Medical Centre premises were visibly clean, tidy and in good decorative order. A programme to replace the windows at the Ashfield Medical Centre had improved the effectiveness of routine cleaning and assisted in reducing sources of dust. Impermeable floor coverings were fitted in the treatment rooms at both sites.

The practice infection control policy identified lead personnel at the practice with responsibility for maintenance of equipment and facilities in clinical and non-clinical areas. The policy included requirements for daily, weekly, monthly and six monthly cleaning tasks and training intervals for staff. Infection control inspection checklists were in use and included separate checklists for each area of the practice and facilities, for example; Waste Management, Hand Hygiene, Cleaning Equipment, Handling Clinical Samples and Room Inspections.

Signage describing hand hygiene techniques was displayed in consulting rooms, treatment rooms and toilets. Hand washing sinks, soap, gel and hand towel dispensers were in use. Signage was also prominently displayed describing procedures for the management of needle stick injuries. Records were kept of staff immunisation status; however, there were no similar checks or records for locum or cleaning staff.

In the treatment rooms sterile single use surgical equipment was neatly stored by batch date ready for use. Supplies of personal protective equipment, including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy. For example, disposable paper rolls were fitted to the examination couches. The couches and headrests were decontaminated between patients and privacy curtains were laundered every six months or sooner if soiled as required by the practice's policy.

There were appropriate arrangements for the segregation and disposal of sharps and clinical and non-clinical waste. The practice's Clinical Waste Management Protocol detailed arrangements for the identification, colour coding, segregation and handling of waste. Reception staff were aware of procedures for accepting patient samples so as to avoid direct handling.

An external audit (by the local NHS Community Healthcare Team) had been carried out in August 2013 and a further annual audit was pending. The audit had identified some areas for improvement but rated the practice overall as 'compliant' in all areas. We were shown a copy of the audit and action plan, which included details of the progress made up to the date of our inspection visit. As part of their own routine monitoring of standards the practice had

identified additional areas of their arrangements for infection control which they wished to improve. For example, record keeping and performance management of the external cleaning contract.

The practice had procedures for the management and testing of the water supply and outlets for the presence of legionella (a bacterium found in the environment which can contaminate water systems in buildings). Records were available which confirmed the practice was carrying out regular checks in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. Records were available detailing the equipment identification, model and serial numbers and test results.

Staffing & Recruitment

The practice provided services from two sites. Staff worked at both sites to ensure consistency of standards and effective team working. A 'buddy' system was in operation which ensured key tasks were completed in the event of any absence. Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. This included covering for planned absences, immunisation campaigns and monitoring overtime working patterns to ensure staff did not work excessive hours.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the workplace environment, management of medicines, staffing, dealing with emergencies and equipment.

Staff were able to identify and respond to changing risks to people who use services, including deteriorating health and wellbeing or medical emergencies and where appropriate seek support from senior staff. For example; one member of staff explained how they had attended training and learnt to empathise with patients who exhibited unreasonable or inappropriate behaviours when they contacted the practice. The member of staff told us they were now aware of the importance of considering whether the behaviour was a response to factors such as pain or stress from the responsibilities of caring for another person.

Older patients (i.e. those over 75 years of age) were offered appointments according to their specific needs or personal circumstances, including home visits. The practice had developed recall systems to maximise the number of patients with long term conditions attending annual reviews. We were told the practice had been recognised as a regional lead by the local Commissioning Support Unit (the NHS body established to support practices and CCG's improve patient care).

Bi-monthly safeguarding meetings were held with health visitors. Six week baby checks were also used to assess risks of domestic abuse. Patients with learning difficulties were offered long appointments and annual reviews and encouraged to be accompanied by a carer. Personalised invitation and recall procedures had been put in place and a member of the reception team had undergone additional training to raise awareness of the needs of these patients. Patients at risk of or experiencing poor mental health, including those with dementia, were screened for depression. Patients with a history of depression had care plans describing how they wished to be treated and cared for at time when they were unable to make decisions for themselves.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff had received training in basic life support and fire evacuation procedures. Emergency equipment was available including emergency oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records shown to us confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. We saw that supplies of emergency medicines kept in the doctor's bags for home visits were in date and fit for use.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the normal operation of the practice. Named members of staff and deputies were allocated specific roles and responsibilities. There were arrangements to establish a crisis management team and procedures to cascade information to other personnel. Contact details were available for all staff, partner organisations and emergency services. The nature of each risk was detailed together with the mitigating actions put in place to reduce and manage the risk. Risks identified included loss of; key staff, premises, communications, information and mains services. The continuity plan also contained contact details for suppliers and emergency maintenance engineers. For example, contact details of a heating company to contact in the event of failure of the heating system.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found the GPs and nurses completed thorough assessments of patients' needs and these were reviewed, when appropriate, in line with recommended guidelines.

Individual GPs were identified as leads in specialist clinical areas such as; diabetes, heart disease or asthma. These roles also involved leading discussions at practice clinical meetings and considering whether changes to existing clinical practice were needed to ensure patients continued to receive good care and treatment. For example, the practice had reviewed the use of a specific nonsteroidal anti-inflammatory medicine (diclofenac) which had been reported to indicate a risk to certain patients. After reviewing their prescribing arrangements the GPs changed to an alternative medication which was judged to be safer for patients. The practice planned to carry out a further audit on prescribing usage to assess the effectiveness of this change in medication and their performance in relation to other practices.

Management, monitoring and improving outcomes for people

Quality Outcome Framework (QOF) data for 2012-13 showed that the practice had obtained the maximum amount of points in all areas and was performing above the local Clinical Commissioning Group (CCG) and England averages. A similar level of achievement was expected for the 2013 -14 data, with the practice forecasting a score of over 99%. Significantly this was achieved with lower than average exception rates, i.e. patients excluded from the results for reasons such as failing to attend reviews or refusing treatment.

Whilst reviewing their QOF data the practice had also identified that improvements were needed in the identification and management of diabetes and chronic obstructive pulmonary disease (COPD). As a result the practice had improved its screening of at risk patients and identified those likely to develop diabetes and arranged for them to attend annual reviews. Similarly diagnosis of COPD was found to be lower than expected for the practice population. This led the practice to improve screening, specifically for smokers over the age of 35, which resulted in the identification of additional patients with early signs of COPD.

The practice had developed this work and adopted the 'Year of Care' approach for patients with COPD. This NHS initiative was developed to improve the delivery of personalised care to patients with long term conditions, such as diabetes or COPD, and support them to take greater control of the management of their care and treatment. The practice had provided patients with additional information, including a copy of their care plan and their test results. This encouraged patients to be more proactive about their condition and aware of when to seek help.

To further support patients with long term conditions the practice had reassessed their procedures for annual reviews and introduced measures to carry out full assessments during a single appointment so as to avoid the need for patients to attend multiple appointments on different dates.

The Practice had systems in place for completion of clinical audits. For example we were shown details of an audit of antibiotic prescribing for respiratory infections. The practice was able to show the extent to which the local protocols (Leeds Health Pathway) and national (NICE) prescribing guidance had been followed. Learning from the initial audit was implemented and a follow-up audit demonstrated the extent to which prescribing practice had improved. The practice had then put in place a further action plan to increase the use of the local protocols.

Effective staffing

The partners at the practice were proactive in monitoring staffing needs and promoting effective team working across the two sites. Staff rotated between each site so as to ensure consistency in working procedures and services to patients. There was also an acknowledgement that further strengthening of the non-clinical management team was needed. As a result the practice had recently advertised the post of practice manager and had scheduled interviews for potential candidates. It was

Good

Are services effective?

(for example, treatment is effective)

anticipated that, once in post, the new manager would add valuable capacity to the management team, strengthening performance management, financial control and human resources.

Staff felt they had the appropriate qualifications, skills, and experience to carry out their roles. They felt able to ask for advice and support at any time. For example, the lead nurse manager was provided with additional administrative support to relieve pressure on clinical time. Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained and supported to fulfil these duties. For example; cervical cytology, chronic wound management and immunisations. Those with extended roles, such as the management of diabetes and insulin initiation, were also able to demonstrate they had appropriate training to fulfil these roles. The practice provided opportunities for doctors who were training to be general practitioners to gain practical experience of primary care. The trainees were able to seek advice from their supervisor during surgery times and if necessary seek a second opinion whilst the patients were still at the practice.

New members of staff underwent a period of induction. They said they felt well prepared and would have been given more time to become confident in practice procedures had they requested it. Staff felt valued and said team working was good. The practice encouraged staff to achieve high standards. A staff 'Recognition Scheme' had been introduced to acknowledge outstanding behaviour or performance. Staff said they took pride in being acknowledged by colleagues.

The practice had an annual staff training and communication programme. Staff underwent annual appraisals which identified their learning needs from which action plans were prepared. Staff told us that the practice was proactive in encouraging them to undergo further training and development related to their role, for example; meeting the needs of patients with learning disabilities. There was also support for staff to improve their performance through agreed Performance Improvement Plans which described the expected standards, support available and desired outcomes.

Working with colleagues and other services

Clinical and non-clinical staff were involved in assessing, planning and delivering people's care and treatment. For example administrative staff had helped to; develop clinical read coding for certain conditions, plan flu clinics and coordinate annual reviews. Staff working on the reception desks or taking telephone calls from patients were able to alert the clinical staff as to any potential concerns or problems before the patient started their appointment with the doctor or nurse.

The practice clinical IT system was configured to prompt staff to follow up urgent referrals and test results. Procedures were in place to direct electronic letters from hospitals or the out of hour's service to the appropriate member of the clinical team for action. Similarly patient information received by post was checked and scanned and added to the relevant patient's clinical record.

Information Sharing

Staff from the local palliative care team regularly attended practice clinical team meetings to review patients receiving end of life care. The practice had established close links with the local hospice and also supported patients who wished to remain at home. The practice liaised with the Macmillan nurses to ensure prescribed medication was available when needed. Protocols were in place for 'anticipatory drugs' i.e. medicines which are likely to be required and can therefore be offered to the patient without delay and in some cases prevent admission to hospital.

Consent to care and treatment

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. The doctors told us they obtained written consent for invasive procedures such as joint injections or contraceptive implants and attached a copy to the patient's clinical record. Where a patient was accompanied during their appointment the doctors told us they took care to address the patient, not their carer, and if appropriate complete a mental capacity assessment. When necessary carers were involved in supporting patients to understand why their consent was needed.

When providing care and treatment for children and young people assessments of capacity to consent were carried out in line with relevant guidance and staff had a clear

Good

Are services effective?

(for example, treatment is effective)

understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

The reception areas at both surgeries included a variety of health promotion information and advice leaflets. The practice produced quarterly 'seasonal' newsletters which provided information about the practice and any current initiatives. The most recent newsletter (Autumn 2014) included information about the seasonal flu and shingles vaccinations.

All new patients were offered an initial health check. Health checks were also offered to patients aged 40 to 74 years of age. An alcohol counsellor provided advice and support session each week. A Health Trainer also visited the practice twice a week and offered extended appointments.

Where appropriate patients were signposted to other services, including referral to a local gym. A local scheme also allowed patients free access, at specified times, to a leisure centre. Automatic blood pressure monitors had been installed together with clear guidance on their use. Patients were encouraged to measure their own BP and hand the printed results sheet to the reception staff for checking by the practice nurse and adding to their clinical record.

The practice had also identified the smoking status of 90% of patients over the age of 15 years and offered support and treatment to these patients. This figure was above both the local CCG and England averages. Performance for cervical smear uptake was 80% which slightly below the average for the CCG but above the England average. The practice had protocols to follow up abnormal results and patients who failed to attend.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Staff told us they had received training to support them to deal sensitively with patients and respond to concerns. During our visit we noted staff welcoming patients. They were familiar with the majority of patients who attended during the day and showed appropriate warmth, friendliness and courtesy.

We reviewed the most recent GP Patient Survey data available for the practice on patient satisfaction. Of the 123 patients who replied;

- 93% found the receptionists at the surgery helpful.
- 92% said the last GP they saw or spoke to was good at treating them with care and concern.
- 86% said last nurse they saw or spoke to was good at treating them with care and concern.
- 72% were satisfied with the level of privacy when speaking to receptionists at the surgery.

These results were better than the local CCG averages.

In the week before our visit we invited patients to completed comment cards to provide us with feedback on the practice. We received 29 completed cards, the great majority of which were positive about the staff. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. Several specifically commented on the friendliness of the reception staff. We also spoke with seven patients during our inspection. They told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Patients requiring intimate examinations were offered a chaperone. The reception staff had received appropriate training and were able to describe the role of the chaperone and how to ensure the patient's privacy and dignity were maintained.

The practice switchboard had been positioned away from the reception window and was shielded by glass partitions which helped keep patient information private. Given the constraints imposed by the building and layout of the reception area the staff endeavoured to ensure privacy was respected. Patients were also able to use a private room adjacent to the reception area.

Care planning and involvement in decisions about care and treatment

The patients we spoke with during our inspection visit told us they felt involved in their care and treatment. They told us that the doctors explained things well and answered any questions they had.

We also reviewed the most recent GP Patient Survey data available for the practice on patient satisfaction. Of the 123 patients who replied;

- 98% said the last GP they saw or spoke to was good at listening to them.
- 90% said the last GP they saw or spoke to was good at explaining tests and treatments
- 80% said the last GP they saw or spoke to was good at involving them in decisions about their care
- 73% said the last nurse they saw or spoke to was good at involving them in decisions about their care

These results were above the local CCG averages.

Staff were attentive to changes in patient's behaviour and recognised when they may need additional support. The practice clinical system also enabled staff to identify patients, either calling or attending the practice, who had particular needs. For example those with a history of mental health problems who needed to be offered an appointment without delay.

Patient/carer support to cope emotionally with care and treatment

The doctors contacted patients who had experienced a bereavement to offer their condolences and support. This included an appointment with a doctor best known to the family or who had been most involved with the person's care. The practice nurses were also able to provide on-going emotional support and additional advice and information about local support services was available on in the reaction areas and 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 had considered the needs of patients and the differing population groups who used the service. The majority of the practice population were English speaking. Language Line translation services were available for those who spoke other languages. Clinical records identified patients with caring responsibilities as well as those being cared for so that staff were alerted to any special support or assistance they may need.

The practice had close links with the local CCG and used information about the needs of local patients to inform how services were planned and delivered. For example the practice had been commissioned to promote bowel cancer screening in support of the local health agenda. Other initiatives had been introduced to; encourage greater self-care for patients with long term conditions, provide extended appointment times for patients with complex needs and coordination of annual screening visits so as to minimise the number of separate appointments people needed to attend.

Tackling inequity and promoting equality

Services were planned, delivered and coordinated to take account of people with complex needs. For example, one member of staff had undergone additional training to improve awareness of the needs of patients with a learning disability. Patients were telephoned to invite them for their annual review and offered flexibility in their appointment times.

The practice supported the registration and treatment for patients, who because of their personal circumstances, were vulnerable and at a higher risk of poor health and/or experienced problems accessing care and support. These included patients who had no permanent address in the area and were living under short term arrangements with friends

Access to the service

Patients were able to book an appointment at either Ashfield Medical Centre or The Grange Medical Centre. Appointments were available between 8am and 6pm each weekday, other than Wednesday afternoons at the Grange and Thursday afternoons at Ashfield when the surgery was closed. Early morning appointments (from 7am) were available at the Ashfield site on Tuesdays and at the Grange site on Thursdays. Information was available to patients about appointments on the practice website and reception areas. This included; how to arrange urgent appointments, home visits, on-line booking and urgent out of hours care when the practice was closed.

The most recent GP Patient Survey data available for the practice included a section on making an appointment. Of the 123 patients who had replied; 94% said the last appointment they got was convenient and 89% said they were able to get an appointment to see or speak to someone the last time they tried. These percentages were above the local CCG averages. However, only 64% of those who replied described their experience of making an appointment as good and only 58% found it easy to get through to the surgery by phone which was below the local CCG average. The patients we spoke with during the inspection visit and the information provided to us on the CQC comment cards also indicated telephone access was poor for some patients.

The Patient Participation Group (PPG) had also completed a patient survey between December 2013 and January 2014. In all 331 responses were received, of which 60% said they had found it easy to contact the surgery by telephone and 40% said contacting the practice poor. We discussed the survey findings with the practice. They were fully aware of the concerns and were addressing the technical difficulties with the telephone system with their telecommunications provider to resolve the problems.

In spite of the problems telephoning the surgeries patients told us they could usually get a convenient appointment and were happy with the service. Patients also said they would be seen if they had an urgent problem. The reception staff confirmed that they could add extra urgent appointments to normal surgery list.

Listening and learning from concerns & complaints

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

Information about the practice's complaints procedure was available to patients and displayed at both surgeries, on

Good

Are services responsive to people's needs?

(for example, to feedback?)

the website and the patient leaflet. Staff had been provided with a flow chart detailing how to handle complaints, including provision for consideration of the complaint at a practice meeting. The practice provided us with a summary of the six complaints received in the previous 12 months. In each case there was summary of the complaint, the date received and responded to and the learning outcomes. For example, a complaint about a locum doctor resulted in improvements to the auditing of patient feedback and updating of the practice's database of preferred locum doctors.

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 and set of values which focussed on meeting the needs of patients. There was evidence of both short and long terms planning. For example; improving complaints and training records, upgrading telephone access, developing shared services, succession planning and premises development to cope with the expanding patient list

The practice's Statement of Purpose described its vision to deliver a 'gold standard service' and 'put patients at the heart of everything we do'. The staff we spoke with talked positively about the practice and shared the aim of performing to a high standard.

GP partners, clinical team and management meetings were scheduled throughout the year. The doctors and lead nurse manager also met twice a year away from the practice to review the practice's vison and strategy. Each meeting addressed a specific theme, for example; 'Team Working' or 'Resilience' through which the practice produced five year development and business continuity plans.

Governance Arrangements

All doctors were allocated lead responsibilities covering both clinical and management roles. There was a systematic programme of clinical and internal audit to monitor the quality of the service and regular reviews of quality improvement activities. Staff were clear about their responsibilities and were supported to achieve high standards. Clear guidance was available describing the expected standards and behaviours of staff, for example; to be patient driven, think flexibly, develop people and secure continuous improvement.

Leadership, openness and transparency

There was strong clinical leadership from the doctors and nurses. They had a good understanding of the practice's strengths and the areas that needed to be improved. They recognised there were weaknesses in the existing management arrangements. In particular there was a need to reallocate some of the management and administrative tasks undertaken by the doctors, improve performance reporting and monitoring of progress in delivering the practice's strategy.

Practice seeks and acts on feedback from users, public and staff

The doctors understood the importance of involving patients and staff and encouraged people to raise concerns. There was an active Patient Participation Group (PPG) with a 165 members. The group met three times a year and was typically attended by 12-15 members. We spoke with three members of the PPG. They spoke very positively about the practice. They felt welcomed and said that their involvement was taken seriously. Details of their meetings were available on the practice website and in the reception areas at both surgeries. Their most recent report, published in March 2014, included an analysis their own patient survey, together with an action plan, reviews of the appointment system, opening hours, patient communications and a profile of PPG members. The practice had worked with the PPG to address the views of patients.

Staff were encouraged to make comments and suggest improvements to the service. They told us they were also kept updated about developments or changes within the practice through team meetings, training days and email.

Management lead through learning & improvement

Staff had a good understanding of importance of managing and learning from significant incidents. Information was shared within the practice and also with the Clinical Commissioning Group (CCG) to facilitate identification of patterns or themes within the practice and CCG area. The practice was a GP training practice and also welcomed student nurses to the practice. In addition to offering supervision and mentoring the practice also sought the lean from feedback from the trainees or students.

Staff spoke highly about the leadership at the practice. They said people were visible and approachable and staff were encouraged to express their views openly. One person told us they had learnt how to 'see things through the eyes of others' as a result of learning by the example set by senior staff. They said that the practice supported them to maintain their clinical professional development through personal development planning.