Ashwell Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

We carried out an announced inspection visit on 17 February 2015. The overall rating for the practice was good. Specifically, we found the practice was good in providing: safe, responsive and effective care for all of the population groups it serves.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action was taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- We found there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.
- Evidence we reviewed demonstrated patients were satisfied with how they were treated and this was with compassion, dignity and respect. It also demonstrated the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

We saw several areas of outstanding practice including:

- The patient participation group (PPG) worked with the practice to provide a voice for the patient and to help develop the service collaboratively. The PPG were also involved with health campaigns for instance diabetes advice and during the flu season promoting vaccinations.

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- The practice actively supported 'Practice Health Champions' who were volunteers. They work in partnership with the practice to find new ways to improve the patients' health with healthy eating groups and walking groups.
- The appointment system was effective providing a mix of open access appointments, emergency and routine appointment. Waiting times for routine appointments were no longer than four days on average.
- A translator for the South Asian languages was available in the practice throughout surgery times to support patients with their language needs.

However, we also found an area in which an improvement was needed.

- While the practice did undertake an annual fire safety check, more frequent audits of their systems was needed as was further training of their staff on actions they should take in the event of fire.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and shared with relevant members of the team. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

It was evident good staffing levels were in place and there was an appropriate mix of skills within the team. We found staff recruitment was managed well with all the required checks in place and there were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff had received appropriate training and further training needs had been identified and planned. The practice had supervision and appraisals in place for all staff.

There were regular GP clinical meetings and evidence of positive working relationships with multidisciplinary teams. National Institute of Health and Care Excellence (NICE) guidance was referenced and used routinely. It was evident in practice and clinical meetings NICE guidelines were discussed and plans made for their implementation.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information and support was available to help patients understand the services available to them. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The GP and staff understood the diverse needs of the different population groups they supported and made arrangements for these to be met. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

Summary of findings

Are services well-led?

Good

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

There was a long standing visible management team, with a clear leadership structure. Staff felt well supported by the management team. There were good governance arrangements and systems in place to monitor quality and identify risk.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice proactively sought feedback from staff and patients, which it acted on.

All staff at the practice met regularly and in addition regular meetings were in place for the clinical staff and administrative staff. Staff also attended weekly in house and monthly multi-disciplinary meetings and with other external networks to promote best practice and organisational development.

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

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

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions, particularly those with diabetes. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

We found the practice completed full health checks on new patients and follow on support for any identified health needs. Special clinics for health needs such as, coronary heart disease, diabetes, asthma and chronic obstructive pulmonary disease (COPD) were held and systems were in place to identify patients who met the criteria to attend.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who may be at risk, for example, children and young people who failed to attend appointments or clinics. Immunisation rates were relatively high for all standard childhood immunisations. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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. The practice held a register of patients with learning disabilities and carried out annual health checks for this group. The practice also offered longer appointments for vulnerable patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patient. We saw evidence of practice staff advising and signposting vulnerable patients to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Good

We saw the practice monitored patients with poor mental health; they used audits to help ensure patients had a regular physical health check and follow ups if there was non-attendance. The practice had good links with the local mental health teams.

The practice offered structured reviews to all patients with severe and enduring mental health conditions with at least annual reviews of their physical and mental health, medicines and revision of their agreed care plan.

Summary of findings

What people who use the service say

The most recent information from Public Health England 2013/14 showed 80% of people were happy with the opening hours.

We received 13 completed patient CQC comment cards and spoke with ten patients on the day of our visit. These patients were positive about the care provided by the GPs, the nurses and reception staff with many comments conveying the good service they received by the practice overall. They felt the doctors and nurses were competent and knowledgeable about their health needs.

The practice had an active Patient Participation Group (PPG). We spoke to a member of the PPG during our visit. They told us they had conducted their own patients survey 2013-2014 and there was also a suggestion box in the practice waiting room. The practice had responded to the patients survey and to individual suggestions by employing more reception and clinical staff to provide better access to the practice.

Areas for improvement

Action the service SHOULD take to improve

Fire safety systems were not monitored regularly and may put people at risk.

Outstanding practice

- The appointment system was effective providing a mix of open access appointments, emergency and routine appointment. Waiting times for routine appointments were no longer than four days on average.
- The patient participation group (PPG) worked with the practice to provide a voice for the patient and to help develop the service collaboratively. The PPG were also involved with health campaigns for instance diabetes advice and during the flu season promoting vaccinations.
- The practice actively supported 'Practice Health Champions' who were volunteers. They work in partnership with the practice to find new ways to improve the patients' health with healthy eating groups and walking groups.
- A translator for the South Asian languages was available in the practice throughout surgery times to support patients with their language needs.

Ashwell 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 SPA, Specialist advisor GP and a second CQC inspector.

Background to Ashwell Medical Centre

Ashwell Medical Centre is located near the centre of Bradford. The building is purpose built with parking facilities and disabled access.

The practice is registered with the CQC to provide primary care services. It provides Primary Medical Services (PMS) for 7810

patients under a PMS contract with NHS England in the Bradford District Clinical Commissioning Group (CCG) area.

The practice has four GP (two male and two female), one advanced nurse practioner, two practice nurses, three healthcare assistants and an experienced administration and reception team. The reception team consists of one practice manager and 10 reception and administrative staff.

The practice was also a training practice for newly qualified clinicians.

The practice is open from 8am to 6:30pm Monday and Friday, 7:30am to 6:30pm Tuesday and Thursday with extended evening opening hours on a Wednesday from 8:00am to 8:00pm.

The practice treats patients of all ages and provides a range of medical services. When the practice is closed patients can access the out of hour's provider service provided by Local Care Direct.

The practice population is made up of a predominately younger and working age population between the ages of 0- 44 years. Forty Two per cent of the patients have a long-standing health condition.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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.

Detailed findings

How we carried out this inspection

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)

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 17 February 2015. During our visit we spoke with a range of staff including the practice manager, three GP partners, one advanced nurse practioner, one practice nurse, two health care assistants and five reception staff. We also spoke with ten patients on the day.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 13 CQC comment cards where patients had shared their views and experiences of the service. We also reviewed records relating to the management of the service.

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to monitor all aspects of patient safety. Information from the Quality and Outcomes Framework (QOF), a national incentive and reward scheme that helps practices to focus on better outcomes for patients, showed that in 2013-2014 the practice was appropriately identifying and reporting incidents. The practice had a rating of 99.6%. Information from the Clinical Commissioning Group (CCG) and NHS England indicated the practice had a good track record for maintaining patient safety. Staff we spoke with understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

Learning and improvement from safety incidents

There were effective protocols used to scrutinise practice. The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events that had occurred during the last 12 months. We saw incidents were discussed at regular clinical and monthly practice meetings. We talked with staff who confirmed any relevant information was passed on to them as and when required. We saw there were regular 'serious events' meetings and staff also told us case studies were presented at meetings to analyse responses and improve outcomes for patients.

We saw where patients had been affected by something that had gone wrong, in line with practice policy; they were given an apology and informed of the actions taken.

Staff told us they felt confident in raising issues with the GPs and felt action would be taken. It was clear there was a culture of openness operating throughout the practice, which encouraged errors and 'near misses' to be reported.

Reliable safety systems and processes including safeguarding

The practice had systems in place to protect and safeguard children and vulnerable adults. The practice had a named lead GP for safeguarding and a safeguarding policy in place which was accessible to staff. All clinical staff had completed both adults and children safeguarding training and received periodic updates. Non clinical staff had completed in-house training and further training was in place to improve their knowledge. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. This helped to ensure the protection of children and vulnerable adults.

We confirmed staff used agreed codes on their electronic case management system for children and vulnerable adults. This highlighted risks to these groups. These were then known and reviewed. The system also flagged up where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer. The practice had systems to monitor babies and children; for instance, where patients failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

There were chaperone notices displayed on all consulting rooms doors and a chaperone policy in place. There was evidence of patients being offered chaperone services during consultation and treatment. Staff had appropriate guidance and we saw evidence they had received in house training.

Medicines management

There was a clear policy which ensured medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Staff confirmed the procedure to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. The staff showed us their daily records of the temperature recordings and the correct temperature for storage was maintained. The cold chain for vaccines was audited and closely monitored by staff. We saw appropriate action had been put in place when there was a recent failure in the cold chain.

The practice was not a dispensing practice. The amount of medicines stored was closely monitored and medicines were kept in a secure store with access by clinical staff only. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of prescribing meetings where prescribing patterns and errors were reviewed. We also saw prescribing

audits were in place for example for the prescribing of Pregablin and Anti-inflammatory medication. The practice had also undertaken an audit on antipsychotic medication in the treatment of behaviour and psychological symptoms of dementia.

There were good systems in place to ensure GPs regularly monitored patients medication regularly. Patients were invited to book a 'medication review', where required.

The nurses and the health care assistant administered vaccines using appropriate directions Patient Group Directions(PGDs) and Patient Specific Directions (PSDs) in line with legal requirements and national guidance. We saw that staff had received appropriate training to administer vaccines. The data from 2013-14 NHS England showed 93% of children aged 24 months at the practice had received their vaccinations.

Cleanliness and infection control

We saw all areas throughout the practice were clean. We saw there were cleaning schedules in place and cleaning audit records were kept in each treatment room. We saw liquid soap and paper hand towels were available in treatment rooms and public areas. Notices about hand hygiene techniques were displayed in staff and patient toilets. We saw hand gel was available in the public areas and treatment rooms to minimise health risk.

Patients we spoke with and responses from the CQC comment cards confirmed patients found the practice clean and had no concerns about cleanliness. We confirmed suitable arrangements were in place to help ensure the practice was cleaned to a satisfactory standard.

We confirmed Personal Protective Equipment (PPE) was easily accessible to all staff. Single use equipment was available and safely managed. Sharps receptacles were in place in the treatment rooms and containers were provided for the disposal of cytotoxic and contaminated sharps such as used needles. The practice had a needle stick injury policy in place, which outlined what staff should do and who to contact if they suffered this injury.

We looked at the Infection Control Policy in place and noted it was up to date and regularly reviewed. The practice had a lead for infection control who completed recent audits to ensure the treatment areas were safe. An infection control checklist was used to help identify any shortfalls or areas of poor practice. Where concerns were identified, an action plan was put in place. We confirmed infection control training had been completed by all the staff and refresher training was on an annual basis.

The practice had a legionella assessment in place and audits were in place.

Equipment

The practice had appropriate equipment for managing emergencies. Emergency equipment included a defibrillator and oxygen. We confirmed equipment was checked regularly to ensure it was in working condition. A log of maintenance of clinical and emergency equipment was in place and staff recorded when any items identified as faulty were repaired or replaced.

We saw the practice had contracts in place for portable appliance tests (PAT), and also for the routine servicing and calibration, where needed, of medical equipment. However we did see checks of the gas and electrical systems were out of date. We discussed this with the provider who said this had been an oversight and agreed they would immediately arrange for these systems to be checked. Following the inspection they sent information to confirm these checks were now underway.

Staffing and recruitment

The practice had a recruitment policy in place. The policy stated all staff should have a Disclosure and Barring Service (DBS) check and references from their previous employment. We looked at a sample of personnel files for nurses, health care assistants and reception staff. Most of the staff had worked for the provider for several years. We looked at the most recently recruited staff and confirmed pre-employment checks were in place. Checks such as obtaining a full work history, evidence of identity, references and a DBS check, had been carried out prior to staff starting work.

The provider routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register each year to make sure they were still deemed fit to practice.

Good

Are services safe?

We saw safe staffing levels had been determined by the provider and rotas showed these were maintained. Procedures were in place to manage planned absences, such as to cover training and annual leave, and unexpected absences such as staff sickness.

Monitoring safety and responding to risk

The practice management team looked at safety incidents and any concerns raised. They then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner.

The practice was positively managing risk for patients. Patients with a significant change in their condition or new diagnosis were discussed at GP and multi-disciplinary team (MDT) meetings, which allowed clinicians to monitor treatment and adjust support according to risk. We saw information regarding palliative care patients was made available to out of hours providers so they would be aware of changing risks. We were also told a dedicated line was made available to frail patients who needed more immediate support.

The practice had arrangements which monitored safety and responded to changes in risk to keep patients safe. For example, the practice had a health and safety policy setting out the steps to take to protect staff and patients from the risk of harm or accidents.

We found that whilst the fire system was checked annually there appeared to be no regular audit of the fire systems in the building. We were also concerned the staff at the practice had not received fire training. We discussed this with the provider who agreed they would seek advice from the fire authority and arrange for these systems to be made safe.

Arrangements to deal with emergencies and major incidents

We saw evidence all staff had received training in Basic Life Support. This was updated annually. There was an automatic external defibrillator (AED) in the practice. All staff knew where this was kept and how it should be used. Emergency medicines were available, such as for the treatment of cardiac arrest and anaphylaxis, and all staff knew their location.

We saw there were disaster/ business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to all staff and kept in reception. This provided information about contingency arrangements staff would follow in the event of a foreseeable emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure. The practice achieved 99.6 per cent of the QOF framework points in year 2013-14, which showed their commitment to providing good quality of care.

GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For instance, they applied the NICE quality standards and best practice guidance in their management of conditions such as asthma and diabetes. We saw minutes of GP clinical meetings where new guidelines were disseminated and the implications for the practices and the practice performance and patients were discussed. The GPs we interviewed were aware of their professional responsibilities to maintain their knowledge.

We saw patients were appropriately referred to secondary and community care services. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring each patient was given support to achieve the best health outcome for them. Feedback from patients confirmed they were referred to other services or hospital when required

There were systems in place to identify and monitor the health of vulnerable groups of patients. Specific coding was used for patients on their electronic records. This coding recorded the everyday care of a patient, it included family history, relevant tests and investigations, past symptoms and diagnoses. This helped to improve patient care by ensuring clinicians based their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when they assessed patients' conditions.

Staff were able to demonstrate how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers, for patients with long term conditions. These included asthma and chronic heart disease and were used to arrange annual, or as required, health reviews.

The practice had identified there was a high prevalence of diabetics in their patient population. To enable them to manage this risk to patients effectively they held regular diabetic clinics and were involved in the Bradford Beating Diabetes campaign. A patient told us they had been provided with information about the risks of diabetes and healthy lifestyle and diet. Staff involved with the clinics told us they had received training in diabetes disease management.

We saw patients were appropriately referred to secondary (hospital) and community care services. The GPs and nursing staff we spoke with clearly outlined the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring each patient was given support to achieve the best health outcome for them. The practice had a dedicated member of staff who supported patients to use the choose and book system. Feedback from patients confirmed they were referred to other services or hospital when required

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included, dementia and blood pressure monitoring audits. The practice was able to demonstrate the changes resulting since the initial audit. For example, the practice had demonstrated improvement in the reduced prescribing rates of anti-inflammatory medicines.

Staff regularly checked all routine health re assessments were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked patients who received repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

We looked at the most recent results from the quality and outcomes framework (QOF) 2013-2014. QOF is a national performance measurement tool. This demonstrated 86.0% of patients with dementia had their care reviewed within

Good

Are services effective?

(for example, treatment is effective)

the preceding 15 months. The QOF data demonstrated the processes for monitoring the health needs of patients with diabetes were good. The percentage who had their cholesterol levels checked within the preceding 15 months was 90% compared to a national average of 93%. The rate of patients in this group who had a dietary review was 91% compared to a national average of 82%. se

s effective)

The GPs from the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration.

The practice had processes in place which covered child health and family support. This included a programme of health and development reviews. These were to allow them to assess growth and development of young children, identify risk factors and opportunities for improving health.

It also gave parents the opportunity to routinely discuss any concerns they had about their children. This ran from an initial neo-natal examination within the first 72 hours of birth through to vaccinations up to the age of 18 years.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us they had a register of patients who had a learning disability and also those with poor mental health. They also told us annual health checks were carried out for patients on these registers. QOF data demonstrated registers were in place and those patients were having their health needs assessed on a regular basis.

Effective staffing

The patients we spoke with were complimentary about the staff. We observed staff were competent and knowledgeable about the roles they undertook. The practice was organised so there were enough staff to meet the fluctuating needs of patients.

There was a good skill mix within the clinical team with practioners specialising in different areas to provide positive support for the health needs of the population groups. For instance clinicians specialised in areas such as diabetes, urology, women's health and dermatology.

We saw checks were made on qualifications and professional registration as part of the recruitment process and additional checks throughout the clinician's appointment. There was a comprehensive induction programme in place for new staff which covered generic issues such as health and safety and infection control. We saw evidence staff had completed mandatory training, for example basic life support, safeguarding and infection control.

We saw evidence of regular 'Target' training days which GPs attended externally and other staff in house. Examples of this included Basic Life Support and QOF's and Audits outcomes. The target also invited external agencies, such as the carers resource to speak at their training days. We saw the practice kept an accurate account of training completed or training requiring an update.

All GPs were up to date with their continuing professional development requirements. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The advanced nurse practioner we spoke with confirmed their professional development was up to date.

The clinical and non-clinical staff confirmed appraisals were in place. All the staff we spoke with were unanimous they were well supported in their role and confident in raising any issues with the practice manager or the GPs.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff. We saw where performance concerns had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

We saw evidence the practice worked closely with other professionals. For example they worked with palliative care nurses, health visitors, social services, alcohol support workers and community mental health teams to support patients.

The staff attended multidisciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

The staff told us they liaised closely with the health and social care providers to ensure any health needs of their patients were promptly addressed, for example when someone was discharged from hospital. This was important to ensure integrated care and support was provided to the patients.

There was a practice website with information for patients which included signposting services available and the latest news. Patients registered so they could access the full range of information on the website. Information leaflets and posters about local services were available in the waiting area.

A translator for the South Asian languages was available in the practice throughout surgery times to support patients with their language needs.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties with respect to these. We saw clinical staff were familiar with the need for capacity assessments and Gillick competency assessments of children and young people. These assessments checked whether children and young people had the maturity to make decisions about their treatment.

Staff told us they spent time discussing treatment options and plans with patients and were aware of consent procedures. They explained discussions were held with patients to assure their consent prior to treatment. They were aware of how to access advocacy services. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. There was a practice policy on consent in place. Staff were able to provide examples of how they dealt with a situation if someone was unable to give consent, this included escalating this for further advice to a senior member of staff where necessary. We found clinical staff understood how to facilitate 'best interest' decisions for people who lacked capacity and would seek appropriate approval for treatments.

Health promotion and prevention

The practice raised patients' awareness of health promotion. This was in consultations, via links on their web site and leaflets in the practice. This information covered a variety of health topics which included alcohol support, smoking cessation and weight management. Patients confirmed with us they had access to the information and staff regularly discussed health promotion with them during their consultations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed reception staff engaged with patients in a respectful and sympathetic way. They listened to patients, were sensitive and responded appropriately.

We saw the practice switchboard was located in an area away from the reception so calls could not be overheard. The staff we spoke with told us they were always careful about what questions they asked patients at the reception desk. They were aware of the need to maintain confidentiality.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so patient's privacy and dignity was maintained during examinations, investigations and treatments. We noted doors were closed during consultations and conversations taking place in these rooms could not be overheard. The staff were aware of the practice policy on chaperoning and were familiar with arrangements to maintain the dignity and privacy of patients undergoing intimate examinations.

Patients' on going emotional needs were supported. Patients were offered information and support for areas such as; bereavement counselling, mental health support and support with conditions such as cancer. Staff confirmed additional support was given to patients after bereavement in their family.

Care planning and involvement in decisions about care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the national GP patient survey in 2013-14, 93% of respondents had confidence and trust in the last GP they saw or spoke to.

They also expressed their GP had satisfactorily explained their condition and the treatment they needed. Patients we spoke with said they had been involved in decisions about their care and treatment, and staff explained things clearly to them.

We found staff communicated with patients so they understood their care, treatment or condition. We received positive comments from patients confirming they understood their treatment and options were discussed during their consultation.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection told us staff were caring and were positive about the emotional support provided by the practice. The CQC comment cards we received were also consistent with this feedback. For example, patients commented the GPs and staff knew them well and were caring, reassuring and supportive.

The practice routinely asked patients if they had caring responsibilities. They were offered additional support and GPs informed them of a local carer support group. Notices in the patient waiting room also signposted people to a number of support groups and organisations.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a service

Patients who experienced poor mental health received treatment, care and support at the practice and in the community when they needed it. The practice held a register of its patients known to have poor mental health and had effective procedures to invite patients to attend an annual health review. The practice worked in conjunction with the local mental health teams.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and for those living in deprived areas. We found GPs and other staff had the overall competence to assess each patient and were familiar with individual's needs and the impact of their socio-economic environment.

Longer appointments were made available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. There was a register of the housebound and patients who required palliative care.

We saw there was a process in place for 'Choose and Book' referrals to other services. We saw referrals the practice made to other services and saw patient were supported to make on going appointments.

We looked at how the practice met the needs of older people. We saw the practice had a named GP for over 75s and provided patients with an 'elderly health check' to support them with management of any long term conditions. This included a system that recalled patients annually for a comprehensive review.

Staff understood the lifestyle risk factors that affected some groups of patients within the practice population. We saw the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation programmes, and advice on weight and diet.

Patients with immediate, or life-limiting conditions, were discussed at the weekly clinical meeting to ensure all practitioners involved in their care delivery were up-to-date and knew of any changes to their care needs.

Tackling inequity and promoting equality

There was level access to the building for patients with mobility issues. There was a comfortable waiting area large enough to accommodate patients who used wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice and included baby changing facilities.

The practice offered telephone consultations for patients who found it difficult for whatever reason to attend the surgery.

The practice had recognised the needs of different groups in the planning of its services. The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The practice was accessible for any vulnerable group and operated an open list so that patients who were temporarily resident in the area could register as a temporary resident. The staff culture evidenced that patients could access the practice's services without fear of prejudice.

We saw that there were translation services available for patients who did not have English as their first language. There was a dedicated worker who provided translation services for South Asian languages. Members of the staff team also had differing language skills and a telephone translation service was available for consultation if required.

Access to the service

Of the patients who participated in the national GP patient survey in 2013-14, 83 % of patients said the last appointment they attended was convenient

The practice offered telephone and on line pre bookable appointments. Patients could ring on the day for emergency appointments. On a Monday the practice had an open access appointment system to cope with the demands after the weekend. They had employed additional staff to cope with the demand.

We saw the practice had introduced systems to monitor and manage the high number of calls coming into the practice. They had screens which indicated the amount of calls 'waiting' in the system. This helped the reception manager reallocate work to administrative staff at peak times.

Patients we spoke with told us they always got an appointment the same day if it was an emergency. All children were seen the same day and usually within two hours of contacting the practice. Older patients were also seen the same day and home visits were available when required for housebound patients. Patients confirmed the practice was accessible and they never waited longer than

Good

Are services responsive to people's needs?

(for example, to feedback?)

four days to gain a routine appointment. Patients were also supported by staff reminding them by telephoning of their appointment in certain cases or with texting services to help remind them of a forthcoming appointment.

We saw good systems were in place to help patients order repeat prescriptions. Patients could use the web site, telephone or visit the surgery to order prescriptions.

Opening times and closures were stated on the practice website and in the practice leaflet with an explanation of what services were available.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system. Information on how to make a complaint was available in a practice booklet in reception and on the web site. We noted however this only provided limited information i.e. to contact the practice manager. We discussed this with the provider who said they would expand this information to provide a full explanation of the patients' rights.

There was a suggestion box in the waiting area for patients use and the practice conducted their own patient survey.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice manager kept a log of complaints about the practice. We looked at six complaints over the past 12 months. We saw these complaints were investigated and concluded in accordance with the practice's guidelines and procedures.

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

Staff we spoke with shared joint values about the practice and knew what their responsibilities. All staff spoke positively about the leadership and they felt valued as employees at the practice. Staff told us central to their values was the needs of the patient. They said this was central to the practice in all their decision making, planning and development. All staff felt the practice was an excellent place to work and the organisation encouraged openness and a 'no blame culture'.

We saw there was input from key stakeholders, patients and staff which ensured the practice regularly reviewed their aims to ensure they were being met.

Governance arrangements

There were systems in place to monitor all aspects of the practice. This included risk assessments, clinical audits, infection control, safeguarding and complaints. There were practice leads responsible for all areas within the practice and staff were aware of each other's responsibilities and who they should report to should they have any concerns. There were a range of audits and checks carried out to ensure patients were treated in safe and appropriate premises and that they received safe and high quality care and treatments.

We found effective monitoring took place, and this included audits to ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well led care. The practice had a system in place for completing clinical audit cycles and reviewed the outcomes from theses to change their clinical practices.

The practice had arrangements which identified, recorded and managed risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as management and safety of medicines. We saw the risk log was regularly discussed at clinical meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example in relation to the management of medicines and vaccines.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at three of these policies and procedures, safeguarding, prescribing and infection control. The practice manager took an active role in overseeing and reviewing the protocols, policies and systems in place across the practice to ensure they were effective and consistent. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clinical governance GP lead and a variety of regular meetings were held between the GPs and the practice manager. The practice held regular governance meetings where matters such as performance, quality and risks were discussed. The practice used the Quality and Outcomes Framework (QOF) as an aid to measure their performance. The QOF data for this practice showed it was performing above the averages of the local Clinical Commissioning Group (CCG) and across England as a whole. Performance in these areas was monitored by the practice manager and GPs, supported by the administrative staff. We saw the QOF data was discussed at team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

All clinicians and reception staff told us there was an open culture within the practice and they were happy to raise issues at meetings. Systems were in place to encourage staff to raise concerns and a no blame culture was evident at the practice.

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

The practice had gathered feedback from staff, through staff training days and generally through staff appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. All the staff we spoke with felt they had a voice and the practice was supportive and created a positive learning environment. They all told us they felt valued, supported and knew who to go to in the practice with any concerns.

The practice completed a survey of the patient population with a qualitative questionnaire and took action from these results. For instance we saw the outcomes of the PPG led patient survey The practice access to appointments and improved staffing levels to meet the increasing demands of the service. We also saw a suggestion box was in place and any comments received were acted upon.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG). We had positive feedback from the PPG regarding their role with the practice and on going engagement to improve the quality of the service for the patients. The practice actively supported 'Practice Health Champions' who were volunteers. They worked with the staff to find new ways to improve the service and help to meet the health needs of patients and the wider community.

NHS England guidance stated that from 1 December 2014, all GP practices must implement the NHS Friends and Family Test (FFT), (the FFT is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience can be used to improve services. It is a continuous feedback loop between patients and practices). We saw the practice had recently introduced the FFT; there were questionnaires available at the reception desk and instructions for patients on how to give feedback. The practice manager told us the comments and feedback would be reviewed regularly.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and t they were given protected time to undertake further training.

Ashwell Medical Centre was designated a training practice where GP registrars (trainee GPs) were offered placements to develop their skills and clinical competences. We spoke to some trainees who were placed at the practice. All were unanimous in how well supported they were by the clinical staff and how positive as a learning environment the organisation was. We also saw additional feedback from previous trainees who had confirmed this.