

The Medical Centre - Driffield

Quality Report

The Medical Centre
Cranwell Road
Driffield
East Yorkshire
YO25 6UH

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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



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Medical Centre - Driffield on 16 June 2016. The overall rating for the practice was good and the rating for the safe domain was requires improvement. The full comprehensive report on the June 2016 inspection can be found by selecting the 'all reports' link for The Medical Centre - Driffield on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 10 May 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 21 June 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice was now rated as good.

Our key findings were as follows:

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

We asked the practice to send us information to confirm that they had addressed other areas identified at the inspection in June 2016 that should improve. These included:

- A new schedule of meetings had been introduced to ensure that learning from incidents was shared with the whole practice team.
- A process was in place to monitor that all staff were up to date with mandatory refresher training.
- A business development plan was in place which set out the practice plans for the future.
- There was a rolling programme of review of policies and procedures and all policies had an annual review date added, as well as an issue date and version control.

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?

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

Good



Summary of findings

The six population groups and what we found

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

Summary of findings

The Medical Centre - Driffield

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector and included a CQC Medicines Inspector.

Background to The Medical Centre - Driffield

The Medical Centre – Driffield, Cranwell Road, Driffield YO25 6UH is located in the centre of the market town of Driffield and is close to local bus routes. There is a car park available next to the practice. The practice is in a purpose built building with disabled access and consulting and treatment rooms available on the ground and first floors; there is no lift access to the first floor. The administration staff are based in a separate building which is a five minute walk from the practice. There is one branch site, Wetwang Surgery, 48 Southfield Road, Wetwang YO25 9XX which is located in the village of Wetwang which is approximately six miles from Driffield. There is disabled access and all consulting and treatment rooms are on the ground floor. This site was also visited during the inspection.

The practice provides services under a General Medical Services (GMS) contract with the NHS North Yorkshire and Humber Area Team to the practice population of 10290, covering patients of all ages. The practice covers a large rural area of approximately 400 square miles. The practice is a 'dispensing practice' and is able to dispense medicines for patients who live more than one mile from the nearest pharmacy. The practice dispenses medicines for approximately half its patients.

The proportion of the practice population in the 65 years and over age group and the under 18 age group is similar

to the England average. The practice scored seven on the deprivation measurement scale, the deprivation scale goes from one to ten, with one being the most deprived. People living in more deprived areas tend to have a greater need for health services.

The practice has five GP partners and a salaried GP, all are part time. There are two female and four male GPs. There are two nurse prescribers, four practice nurses and three health care assistants. Two work full time and seven work part time, all are female. There is a practice manager and a team of administrators, secretaries and receptionists. There are eight dispensers and a trainee dispenser.

The Medical Centre – Driffield is open between 8am to 6pm Monday to Friday. Appointments are available from 8am to 5.30pm Monday to Friday. The Wetwang surgery is open between 8.15am and 12pm Monday to Friday and 3.30pm and 6pm Monday, Tuesday and Friday. Appointments are available from 8.15am to 11.30am Monday to Friday and from 3.30pm and 5.30pm Monday, Tuesday and Friday. Information about the opening times is available on the website and in the patient information leaflet – Booking Appointments.

The practice, along with all other practices in the East Riding of Yorkshire CCG area have a contractual agreement for the Out of Hours provider to provide OOHs services from 6.00pm. This has been agreed with the NHS England area team.

The practice has opted out of providing out of hours services (OOHs) for their patients. When the practice is closed patients use the NHS 111 service to contact the OOHs provider. Information for patients requiring urgent medical attention out of hours is available in the waiting area, in the practice information leaflet and on the practice website.

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of The Medical Centre - Driffield on 16 June 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good overall and requires improvement for the provision of safe services. The practice was given a requirement notice in relation to the safe management of medicines. The full comprehensive report following the inspection in June 2016 can be found by selecting the 'all reports' link for The Medical Centre - Driffield on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of The Medical Centre - Driffield on 10 May 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with a range of staff including the GP lead for the dispensary, the dispensary team leader and dispensers.
- The medicines inspector visited both practice locations and the lead inspector reviewed information sent by the practice in relation to improvements required following the last inspection.

Are services safe?

Our findings

At our previous inspection on 16 June 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of the safe management of medicines were not adequate.

These arrangements had significantly improved when we undertook a follow up inspection on 10 May 2017. The practice is now rated as good for providing safe services.

Overview of safety systems and process

We carried out a follow up inspection on 10 May 2017. We checked the arrangements for managing medicines at the practice. The arrangements for managing medicines across the practice had been reviewed since our last inspection and systems and processes kept people safe.

Prescriptions were dispensed at The Medical Centre Driffield and at the satellite surgery in Wetwang for patients who did not live near a pharmacy. The practice had appointed a new lead GP who was responsible for oversight of the dispensary and worked closely with the dispensary team leader.

The practice had reviewed and updated all standard operating procedures (SOPs); these are written instructions about how to safely dispense medicines. All SOPs had version control and date of review recorded. We saw evidence that the amended SOP's had been read and signed by staff, and they were working in line with the updated procedures.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). These were stored securely in line with legislation and records were accurate.

An updated procedure had been put in place to record incidents. Staff kept a 'near-miss' record (a record of dispensing errors that have been identified before medicines have left the dispensary). Incidents including significant events and near misses were reviewed and this was discussed with the lead GP. Analysis of incidents was discussed with all dispensary staff to aid continual learning and improvement.

The practice had developed a clear procedure for repeat medicines reviews. The roles and responsibilities were understood by all staff involved in the process of prescription generation. Clear procedures were followed when medicines reviews were required and the computer system had been modified to ensure prescriptions could not be re-authorised without appropriate checks. All prescriptions we checked had had medicines reviews documented and recorded appropriately.

The practice had clear procedures in place to ensure that prescriptions were signed before they were handed out to patients. All prescriptions which were awaiting collection had been signed by a doctor and had not surpassed their six monthly validity.

The process for recording medicines fridge temperatures was not consistent between sites, however we brought this to the attention of staff, who rectified this during our visit.

Blank prescription forms were stored securely in accordance with national guidance and the practice had a system in place to track their use.