Lavender Grove Surgery

Quality Report

1A Lavender Grove
York. YO26 5RX
Tel: 01904 798262
Website: www.priorymedical.com

Date of inspection visit: 4 December 2014
Date of publication: 25/06/2015

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

This is the report of findings from our inspection of Lavender Grove surgery which is part of the Priory Medical Group. The practice is registered with the Care Quality Commission to provide primary care services.

We undertook a planned, comprehensive inspection of Lavender Grove surgery on 4 December 2014. There are nine surgeries in the Priory Medical Group (PMG) across the York Clinical Commissioning Group (CCG) area.

Overall, we rated this practice as good.

Our key findings were as follows:

- The practice provided services to the local community, which had been designed to meet the needs of the local population. Patients registered with this practice are

able to access all services at the other nine practices in the Priory Medical Group (PMG).

- Patients told us they were treated with dignity and respect.
- The practice performed well in the management of long term conditions.
- Patients could access appointments without difficulty, and were happy with the telephone and repeat prescribing systems.
- The practice had a good governance system in place, was well organised and actively sought to learn from performance data, complaints, incidents and feedback.
- The building was safe for patients to access, with sufficient facilities and equipment to provide safe effective services.

We saw some areas of outstanding practice including:

- Enhanced care plans and communication/education with care homes including twice weekly ward rounds.
- There was a dedicated teenage health clinic one evening per week, which had been designed with the help of pupils from two local schools, to make the clinic as teenage friendly as possible.
- There was an in-house educational programme, where clinical staff could access evening training meetings every six weeks or so. There was also multi-disciplinary learning for nurses, health care assistants and doctors. Health visitors were also invited to attend. These took place during the day and protected time was allowed for staff to attend three per year.

Summary of findings

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 their roles and responsibilities in raising concerns, and reporting incidents. Lessons were learned from incidents. The practice shared learning across the practices within the (PMG) to maximise learning. The practice had assessed risks to those using or working at the practice and kept these under review. There were sufficient emergency procedures in place to keep people safe. There were sufficient numbers of staff with an appropriate skill mix to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Quality data showed patient outcomes were at or above average for the locality. Guidance from the National Institute for Health and Care Excellence (NICE) was referred to routinely, and patient's needs were assessed and care planned in line with current legislation. This included promotion of good health and assessment of capacity where appropriate. Staff had received training appropriate to their roles. Clinical staff undertook audits of care and reflected on patient outcomes. The practice worked with other services to improve patient outcomes and shared information appropriately.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients gave us positive feedback where they stated that they were treated with compassion, dignity and respect, and involved in their treatment and care. The practice was accessible. In patient surveys, the practice scored highly for satisfaction with their care and treatment, with patients saying they were treated with care and concern, and felt involved in their treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had a good overview of the needs of their local population, and was proactive in engaging with the Clinical Commissioning Group (CCG) to secure service improvements. The practice had good facilities and was well equipped to meet patients need. Information was provided to help people make a complaint, and there was evidence of shared learning with staff. Patients told us it was generally easy to get an appointment, with urgent appointments available the same day. Late evening and Saturday morning appointments were available at different surgeries within the group, with all patients able to access these.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. They were patient centred, forward thinking and committed to improving patients' health. There was a clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor quality and identify risk. The practice had an active Patient Participation Group (PPG), and was able to evidence where changes had been made as a result of PPG and staff feedback.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. The practice participated in a nursing home scheme where GP's visited the local nursing home to carry out a 'ward round' twice a week. This was rotated between all GPs with protected time allowed for this. The practice held monthly palliative care and multi-disciplinary meetings to discuss those with chronic conditions or approaching end of life care. Enhanced care plans had been produced for those patients deemed at most risk of an unplanned admission to hospital. Information was shared with other services, such as out of hours services and district nurses. Nationally reported data such as the Quality and Outcomes Framework (QOF) showed the practice had good outcomes for conditions commonly found in older people. The over 75's had a named GP. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All doctors, nurses and receptionists had carried out training to be 'Dementia Friends' and promoted dementia awareness within the practice.

We saw that personalised care plans had been developed for patients who were at risk. The PMG provided a team of community nurses in partnership with NHS York District Hospital Foundation Trust. This group provided nursing support and assessments to housebound patients seven days a week. The PMG were responsible for implementing a community team which was made up of care managers and health and social care assistants to support patients and assess patient's needs. This helped patients remain independent and avoid unnecessary admission to hospital.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered. People with conditions such as diabetes and asthma attended regular nurse clinics to ensure their conditions were monitored, and were involved in making decisions about their care. Nurses communicated with a clinical lead GP for each condition. For those people with the most complex needs, the named GP and or specialist nurses worked with relevant health and care professionals to deliver a multidisciplinary

Summary of findings

package of care. The staff had received appropriate training in the management of long term conditions. Attempts were made to contact non-attenders to ensure they had required routine health checks.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people. Systems were in place to identify children who may be at risk. For instance, the practice monitored levels of children's vaccinations and attendances at A&E. Immunisation rates were high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Antenatal clinics were run by district midwifes with most care delivered at the practice.

The PMG have developed a teenage health clinic, and had consulted with students from two local schools to make the clinic teenage friendly. Services were provided for 11 to 19 year olds with booked appointments and a drop in service one evening a week. This ensured that young people had access to an age appropriate, dedicated service. There was a dedicated area on the website for advice and health promotion information for teenagers. The practice carried out a daily surgery at a local independent boarding school in its area.

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 population had been identified, and services adjusted and reviewed accordingly. Routine appointments could be booked in advance, or made online. Repeat prescriptions could be ordered online. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. We saw that the practice provided a range of services patients could access at times that best suited them or close to their work by accessing an evening or Saturday morning appointment in one of the other practices within the PMG.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. Patients or their carers were able to request longer appointments if needed. The practice had a register for looked after or otherwise vulnerable children and also discussed any cases where there was potential risk or where people may become vulnerable. The computerised patient plans were used

Summary of findings

to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns. We saw that the practice and medical group had also developed links with Lifeline. This is a project operating in the city that works with individuals, families and communities to prevent and reduce harm and promote recovery linked with alcohol and drug misuse.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Nationally reviewed data showed the practice performed well in carrying out additional health checks and monitoring for those experiencing a mental health problem. People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It also carried out advance care planning for patients with dementia. Staff had received training on how to care for people with mental health needs and dementia, with a number of staff being trained as 'Dementia Friends'.

Summary of findings

What people who use the service say

We received 28 completed CQC comment cards which patients filled in prior to the inspection. We also spoke with two patients who were using the service on the day of inspection. The patients we spoke to and the comment cards indicated they were satisfied with the service provided. Patients said they were treated with dignity, respect and care, and that staff were thorough, professional and approachable. Patients said they were confident with the care provided, and would recommend the practice to friends and family. They told us they found the staff to be caring, supportive, and provided them with a consistently high level of care. We observed a friendly relaxed environment between staff and patients.

We saw that the practice were continually seeking feedback from patients to shape and develop services in the future. We saw that patient views were listened to and the results of patient surveys reviewed quarterly. We looked at the latest quarterly survey results, which had 71 responses from 'two minute surveys' completed in the practice. 63% said their experience of getting through on the phone was average or above. 82% rated the manner of the doctor they saw as above average or excellent, and 90% for the nurse they saw.

The practice had an established proactive patient participation group (PPG). The PPG representatives from the different practices in the PMG met together as one group. They had been responsible for a range of initiatives and changes, for example conducting patient surveys in care homes, being involved in a care in the community initiative and being trained by the ambulance service as first responders. (Community first responders are volunteers trained to attend emergency calls received by the ambulance service in their local area and provide care until the ambulance arrives).

We found that the practice valued the views of patients and saw that following feedback from surveys changes were made in the practice. The PMG were currently in the process of improving the whole telephone system.

Lavender Grove Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a specialist advisor GP, and a Practice Manager.

Background to Lavender Grove Surgery

Lavender Grove Surgery provides primary medical services to approximately 5,400 patients in the York Clinical Commissioning Group (CCG) area. They are part of the Priory Medical Group (PMG) which is a General Practice Partnership open to all patients living within the Practice boundary in York and the surrounding areas.

The PMG has nine practices in the York area and are responsible for a population of 54120. Patients registered with PMG can at attend any of the nine surgeries if this is more convenient.

At this practice, there are five GP's, four female and one male. Patients can be seen by a male or female GP as they choose. There is a practice nurse and a healthcare assistant based at the practice, and a team of other nursing staff who divide their time between surgeries. They are supported by a team of management, reception and administrative staff. The practice is a training practice and supports a GP registrar and third year medical students.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; family planning; surgical procedures, and treatment of disease, disorder and injury. The practice has a mixed demographic and covers some more affluent and some more deprived areas.

The practice has opted out of providing Out of Hours services, which patients access through the 111 service.

Why we carried out this inspection

We carried out the inspection 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.

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?

Detailed findings

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 our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service.

We reviewed the practice's policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We carried out an announced inspection on 4 December 2014.

We reviewed all areas of the surgery, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with the practice manager, GP's, nursing staff, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hour's team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Prior to inspection the practice gave us a summary of significant events from the previous 12 months.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. The practice worked with the Clinical Commissioning Group (CCG) in reporting incidents as necessary.

There were systems in place to record and circulate safety and medication alerts received into the practice. From our discussions we found GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practice.

Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed the practice was appropriately identifying and reporting significant events.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the previous year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

We saw where incidents had been discussed and reviewed, and learning points documented. Incidents were discussed daily at GP meetings, and immediate actions agreed and implemented. These were then summarised and discussed at six monthly significant event meetings.

We did find that this information was not then cascaded widely to enable all learning opportunities to be taken. For instance staff were given feedback on a one to one basis, with incidents not necessarily discussed as a practice, although some information was available via a spread sheet . Reception staff did not have access to incident reporting forms. Incidents were discussed verbally first then a team leader reported. Significant event meetings were held monthly. Staff were able to give examples of where procedures had changed following an incident, for instance a refresher in safeguarding procedures.

We could see from a summary of significant events that where necessary the practice had communicated with patients affected to offer a full explanation and apology, and told what actions would be taken as a result.

National patient safety alerts were disseminated by email or via the intranet. Staff were able to give recent examples of alerts relevant to them and how they had processed them, such as a recall of equipment.

Reliable safety systems and processes including safeguarding

The practice had up to date child protection and vulnerable adult policies and procedures in place. Staff accessed these via the computer system, and which contained contact details for organisations such as social services and the police. Safeguarding meetings were held monthly, which could be attended by health visitors and district nurses.

Procedures provided staff with information about identifying, reporting and dealing with suspected abuse. Staff knew how to access these. Staff were able to described types of abuse and how to report these, and said they felt encouraged to support concerns. The practice had a named GP safeguarding lead, who staff were able to identify. Staff had received training in safeguarding at a level appropriate to their role, and were able to give examples of where they had raised concerns.

The computerised patient plans were used to enter codes to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. The practice had systems to monitor children who failed to attend for childhood immunisations, or who had high levels of attendances at A&E.

The practice had a chaperone policy, and there was information on this service for patients in reception.

Medicines Management

We checked medicines in the treatment rooms and found they were stored securely and were only accessible to

authorised staff. We checked medicines in the fridges and found these were stored appropriately. Daily checks took place to make sure refrigerated medicines were kept at the correct temperature. Refrigerated and emergency medicines we checked were in date and there was a process for checking. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice reviewed its prescribing data through clinical audits and communication with the CCG, and had audited, for example, antibiotic use, and prescribing of high risk medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept securely at all times, however the practice was not logging the numbers on these to ensure traceability. Batch numbers of vaccines were not logged in accordance with good practice.

There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff. They were able to describe an example of a recent alert. This helped to ensure staff were aware of any changes and patients received the best treatment for their condition.

The practice had a prescribing and medication policy which was regularly reviewed and had been agreed with the CCG medicines management team. Members of the nursing staff qualified as independent prescribers received regular supervision and support in their role as well as updates in the specific clinical areas of expertise.

Cleanliness & Infection Control

Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness. The practice had an infection prevention and control (IPC) and hand hygiene policy; however it was not clear when this was last reviewed. We did observe that the blinds in reception were dirty, and the carpet was worn.

There was an identified IPC lead, and an infection control audit had recently been carried out. We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other personal protective equipment (PPE) were available in all treatment areas, as was hand sanitizer and safe hand washing guidance.

Sharps bins were appropriately located, labelled, closed and stored after use. We saw that cleaning schedules for all areas of the practice were in place, with daily, monthly and six monthly tasks. A legionella risk assessment had not been carried out, therefore it was unclear whether all risks had been identified and resolved.

Staff said they were given sufficient PPE to allow then to do their jobs safely, and were able to discuss their responsibilities for cleaning and reporting any issues. Staff we spoke with told us that all equipment used for invasive procedures and for minor surgery were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw other equipment such as blood pressure monitors used in the practice was clean.

We saw evidence that staff had their immunisation status for Hepatitis B checked which meant the risk of staff transmitting infection to patients was reduced. They told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Equipment

We found that equipment such as scales and nebulisers and fridges were checked and calibrated yearly by an external company.

Contracts were in place for checks of equipment such as the fire extinguishers, and fire alarms, and portable appliance testing had been carried out. Review dates for all equipment were overseen by the practice manager.

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us they were trained and knowledgeable in the use of equipment for their daily jobs, and knew how to report faults with equipment.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate

Good

Are services safe?

professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a central rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. The centralised rota system allowed staff to move to different sites to ensure adequate capacity at all sites, this included partner and salaried GP's. Staff said there were sufficient staff numbers for the effective operation of the practice.

Monitoring Safety & Responding to Risk

We found that staff recognised changing risks within the service, either for patients using the service or for staff, and were able to respond appropriately. There were procedures in place to assess, manage and mainly monitor risks to patient and staff safety. These included annual, monthly and weekly checks and risk assessments of the building, the environment and equipment, and medicines management, so patients using the service were not exposed to undue risk.

There were health and safety policies in place covering subjects such as fire safety, manual handling and equipment, and risk assessments for the running of the practice. These were all kept under review to monitor changing risk.

Patients with a change in their condition or new diagnosis were reviewed appropriately and discussed at clinical meetings, which allowed clinicians to monitor treatment and adjust according to risk. We saw that for all patients with long term conditions there were emergency processes in place to deal with their changing conditions. Therefore the practice was positively managing risk for patients. Information on such patients was made available electronically to out of hours providers so they would be aware of changing risk.

Arrangements to deal with emergencies and major incidents

Staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. We saw records confirming staff had received Cardio Pulmonary Resuscitation training. Staff who used the defibrillator were regularly trained to ensure they remained competent in its use. This helped to ensure they could respond appropriately if patients experienced a cardiac arrest. Staff described the roles of accountability in the practice and what actions they needed to take if an incident or concern arose.

A business continuity plan and emergency procedures were in place which had been recently updated, which included details of scenarios they may be needed in, such as loss of data or utilities. Regular fire alarm checks took place and fire drills every six months.

Emergency medicines, such as for the treatment of cardiac arrest and anaphylaxis, were available and staff knew their location. There was also a defibrillator and oxygen available. Processes were in place to check emergency medicines were within their expiry date.

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed and updated when appropriate.

Treatment was considered in line with evidence based best practice, and guidelines and protocols were discussed at monthly clinical meetings. Doctors also met on an informal basis daily. All the GPs interviewed were aware of their professional responsibilities to maintain their knowledge. The nurses attended regular updates and implemented changes as appropriate to ensure best practice. The nurses were supported by the GPs and attended clinical meetings.

Staff were able to demonstrate how care was planned to meet identified needs using best practice templates which were kept under review, 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 such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews. They also provided annual reviews to check the health of patients with learning disabilities and mental illness. The practice could produce a list of those who were in need of palliative care and support, and held end of life planning discussions.

Examples of the monitoring of population needs assessments were the Quality and Outcome Framework (QOF), and audits of unplanned admissions, prescribing and vaccinations. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw there were processes in place to review patients recently discharged from hospital, who were required to be reviewed by their GP. GPs from the practice visited the local nursing home twice weekly, to enable ongoing review of care and care plans and ensure their needs assessment remained up to date.

Patients with long term conditions such as diabetes had regular health checks, and were referred to other services or discussed at multi-disciplinary meetings when required. Feedback from patients confirmed they were referred to other services or hospital when required. National data showed the practice was in line with referral rates to secondary care (hospital) and other community care services for all conditions. All GPs we spoke with used national standards for referral, for instance two weeks for patients with suspected cancer to be referred and seen. We saw evidence that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

Patients requiring palliative care or with new cancer diagnosis were discussed at regular multi-disciplinary care meetings to ensure their needs assessment remained up to date. Palliative care meetings were held monthly.

We saw no evidence of discrimination when making care or treatment choices, with patients referred on need alone.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, recalls and scheduling clinical reviews. The information staff collected was then collated by the practice team leader and the PMG to support the practice to carry out clinical audits.

The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. We saw minutes of meetings and complaints analysis where clinical complaints were discussed and the outcomes and practise analysed, to see whether they could have been improved.

The practice was proactive in participating in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For instance the practice looked at referral or prescribing data and compared these against criteria, then looked to see how patient outcomes could be improved.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes

Good

Are services effective?

(for example, treatment is effective)

framework (QOF). The practice carried out a programme of clinical audits, examples of which included prescribing of an anti-inflammatory medicine, and a review of prescribing for patients diagnosed with hypertension. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines in line with the guidelines. GPs maintained records showing how they had evaluated the findings and documented the success of any changes.

Clinical staff checked that routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up when patients needed to attend for a medication review before a repeat prescription was issued. Similarly when patients needed to attend for routine checks related to their long term condition.

Effective staffing

A computerised training matrix was kept which showed what training had been carried out and when essential training was due. Staff told us the practice was supportive of relevant professional development. GPs met daily for an operational and educational lunchtime meeting, comprising debrief, and discussing patients and visits. More formal meetings were held monthly.

Staff told us there was an in-house educational programme. We saw details of this, where clinical staff could access evening training meetings every six weeks or so. There was also multi-disciplinary learning for nurses, health care assistants and doctors. Health visitors were also invited to attend. These took place during the day and protected time was allowed for staff to attend three per year.

We saw evidence that all GPs had undertaken annual external appraisals and had been revalidated or had a date for revalidation, an assessment to ensure they remain fit to practice. GPs had one week per year study leave for professional training requirements. Continuing Professional Development for nurses was monitored as part of the appraisals process, and professional qualifications were checked yearly to ensure clinical staff remained fit to practice.

We saw evidence that clinical and non-clinical staff had yearly appraisals, which identified individual learning needs and action points from these. New starters had an induction period during which time they received mentoring and training. This comprised health and safety, incident reporting and fire precautions, in addition to further role specific induction training and shadowing of other members of staff.

We saw that the mandatory training for clinical staff included safeguarding and infection control. Staff had access to additional training related to their role. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, and review of patients with long term conditions. Those nurses with extended roles such as seeing patients with long-term conditions like asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff said they felt confident in their roles and responsibilities, and were encouraged to ask for help and support. They gave examples of when they had asked, for instance, a GP or nurse for additional clinical support if they felt unsure.

Working with colleagues and other services

The practice worked proactively with other service providers to meet patients' needs and manage complex cases. The practice held multidisciplinary team meetings monthly 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 other professionals such as health visitors, district nurses and palliative care nurses. Decisions about care planning were documented in a shared care record.

The practice worked with other service such as the local drug and alcohol treatment service and mental health services, in response to patient need, and referred to these. They were proactive in communicating with areas of special need within the practice boundary, such as a bail hostel, nursing home and residential school.

Regular clinical and non-clinical staff meetings took place and staff described the communication within the practice as generally good. Minutes from meetings were typed and circulated via email, although these did not always include actions from the previous meetings or actions for follow up.

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local

hospital including discharge summaries, out-of-hours GP services and the 111 service. These were generally received electronically, although a procedure for faxes and scanning documents was also in place.

Results and hospital letters were processed electronically by GPs daily, and one duty GP also reviewed all results received each afternoon in case urgent action was required. Communications from A&E were dealt with centrally. All staff we spoke with understood their roles and felt the system in place worked well.

Information Sharing

Information was shared between staff at the practice by a variety of means. GPs held management and clinical meetings. Nursing and clinical staff such as healthcare assistants held clinical meetings and had representatives from these groups attend the GPs meetings. Non-clinical staff had regular meetings. Information was also shared via email or the practice computer systems, with staff as part of their duties obliged to check the system at least once a day. Staff said the communication and information sharing was generally good.

Information on unplanned admissions was collated from multi-disciplinary meetings and fed back to the CCG to identify themes and trends.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider and other GP practices in the PMG to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments). Staff reported that this system was easy to use.

The practice has also signed up to the electronic Summary Care Record. The practice had in place a medical records system which allowed the patients care teams instant access to medical records at all of their surgeries. This system enabled staff in the practice to see and treat patients from other practices registered within the group. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

These records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken.

Consent to care and treatment

We found that staff had received training around the Mental Capacity Act 2005, and were able to describe key aspects of the legislation and how they would deal with issues around consent.

For instance, GPs explained examples where people had recorded advance decisions about their care or their wish not to be resuscitated. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

There was a practice policy on consent to support staff and staff knew how to access this, and were able to provide examples of how they would deal with a situation if someone did not have capacity to give consent, including escalating this for further advice to a senior member of staff where necessary. There was a monitoring process to check staff had read the policy.

Staff were able to discuss the carer's role and decision making process. There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

The PMG worked with the CCG and City of York Council on a range of specific initiatives, including a pilot to reduce avoidable admissions and safe discharge from hospital.

The practice asked new patients to complete a new patient registration form and there was a separate form for children under six years. The practice may then invite patients in for an assessment with one of the clinical staff. GPs were informed of all health concerns detected and these were followed up in a timely way.

Good

Are services effective?

(for example, treatment is effective)

Advice was given on smoking, alcohol consumption and weight management. Smoking status was recorded and patients were offered advice or referral to a cessation service. Patients over the age of 75 had been allocated a named GP. Nurses used chronic disease management clinics to promote healthy living and ill-health prevention in relation to the person's condition.

Patients aged 40-75 were offered a health check in line with national policy, to help detect early risks and signs of some conditions such as heart disease and diabetes. In addition to routine immunisations the practice offered travel vaccines, and flu vaccinations in line with current national guidance. Patients could access weekday, evening and weekend travel clinics. Data showed immunisation rates were broadly comparable with the CCG area.

The practice's performance for cervical smear uptake was comparable to the CCG and England average. There was a policy to follow up patients who did not attend for cervical smears and the practice audited rates for patients who did not attend.

There was a dedicated teenage health clinic one evening per week, which had been designed with the help of pupils from two local schools, to make the clinic as teenage friendly as possible. This included a special screened off area in the waiting room, teenage magazines, free squash and information posters designed by local teenagers. There was a dedicated area on the website for advice and health promotion information for teenagers.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the Priory Medical Group on patient satisfaction. This included information from the national patient survey and the '2' minute survey completed by patients.

The evidence showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as good or very good was 85%.

In the latest quarterly survey results, which had 71 responses, 82% of patients rated the manner of their doctor as above average or excellent, and 90% for the nurse they saw.

We received 28 completed CQC comment cards which patients filled in prior to the inspection. We also spoke with two patients who were using the service on the day of inspection. The patients we spoke to and the comment cards indicated they were satisfied with the service provided. Patients said they were treated with dignity, respect and care, and that staff were thorough, professional and approachable. Patients said they were confident with the care provided, and would recommend the practice to friends and family. They told us they found the staff to be caring, supportive, and provided them with a consistently high level of care.

The practice phones were located away from the reception desk which helped keep patient information private. We observed that reception staff were friendly, relaxed and helpful, and maintained confidentiality as far as possible.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were used in treatment and consulting rooms to maintain patients' privacy and dignity during investigations and examinations. There was a chaperone policy and guidelines for staff, and this service was advertised in reception. Nursing staff acted as chaperones where requested, and other non-clinical staff had also been trained.

Care planning and involvement in decisions about care and treatment

In the NHS England GP survey, 86 % of patients said the GP involved them in care decisions, and 88 % felt the GP was good at explaining treatment and results. Both these results were in line with national averages.

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care. Nursing staff provided examples of where they had discussed care planning and supported patients to make choices about their treatment, for instance the decision of diabetic patients whether to start taking insulin, or the level of ongoing intervention the patient wished for their condition. Extra time was given during appointments where possible to allow for this.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. They said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients said the GPs explained treatment and results in a way they could understand, and they felt able to ask questions, and felt sufficiently involved in making decisions about their care. Staff told us there was a translation service available for those whose first language was not English, and we saw information for this in reception.

Patient/carer support to cope emotionally with care and treatment

Patients said they were given good emotional support by the doctors, and were supported to access support service to help them manage their treatment and care. Comment cards filled in by patients said doctors and nurses provided a caring empathetic service.

GPs referred patients to bereavement counselling services, When patients had suffered bereavement, GPs were notified, and the practice called next of kin if they had been involved in palliative care. The practice kept registers of groups who needed extra support, such as those receiving palliative care and their carers, and patients with mental health issues, so extra support could be provided.

Good

Are services caring?

GP's referred people to counselling services where necessary, and the practice website and handbook contained links to support organisation and other healthcare services. Patients could also search under their local area for further advice and support.

The practice provided information and support to patients who were bereaved and for carers. The practice sign posted patients to health and social care workers and referrals were made on behalf of patient's relatives and carers as appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. These were led by CCG targets for the local area, and the practice worked closely with the CCG to discuss local needs and priorities.

The NHS Area Team and CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. Examples of these are frequent unscheduled admissions, the management of substance misuse and access to services.

Longer appointments were made available for those with complex needs, for instance patients with diabetes. Patients could book with a specific GP to enable continuity of care. The practice held a daily surgery at the local independent boarding school.

The practice was proactive in monitoring those who did not attend for screening or long term condition clinics, and made efforts to follow them up. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available. Home visits and telephone appointments were available where necessary.

Tackling inequity and promoting equality

The building accommodated the needs of people with disabilities, incorporating features such as access without steps, parking, disabled car parking, and toilets for wheelchair users. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

There was a practice information leaflet available. It covered subjects such as services available, GP and patient responsibilities, and how to book appointments. There was a hearing loop at reception to assist those hard of hearing.

The practice had recognised the needs of different groups in the planning of its services. For instance GPs worked closely with drug and alcohol services. Patient records were coded to flag to GPs when someone was living in vulnerable circumstances or at risk.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed this training.

Access to the service

Information was available to patients about appointments on the practice website and patient information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

Appointments could be made in person, by telephone or online. The practice promoted its online services via the practice leaflet and website. Appointments could be booked up to two weeks in advance, which helped patients to plan. Urgent appointments could be allocated the same day on clinical grounds, following a telephone assessment.

Appointments were available from 8:30am until 6:00pm Monday to Friday at this practice. However as patients could attend any surgery within the group, they could also access evening appointments until 8:15pm at other surgeries four days a week, and Saturday morning appointments until 11:15am. The practice also offered express clinics at most of the surgeries in the group. These were five minute appointments for a single simple problem.

Patients we spoke to told us they could generally access appointments without difficulty. Opening times and closures were advertised on the practice website, with an explanation of what services were available. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Good

Are services responsive to people's needs?

(for example, to feedback?)

During core times patients could access a mix of doctors, nurses & health care assistants, or clinics such as family planning and for chronic conditions.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to complain was contained in the patient information leaflet in reception, and staff were able to signpost people to this.

We looked at a summary of complaints made from November 2013 to November 2014. We could see that these had been responded to with an explanation and apology. There was a designated responsible person who handled all complaints which was the PMG complaints manager. There was an email address and postal address provided for the complaints manager. We were told by staff that they would always try and resolve a complaint that was raised with them at local level and if this was not possible direct them to the complaints manager.

We saw that information was available to help patients understand the complaints system in the waiting area, in the practice leaflet or the website. 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 summarised and discussed complaints with staff at practice meetings, and was able to demonstrate changes made in response to feedback. Patients we spoke with said they would feel comfortable raising a complaint if the need arose.

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 clear aims and objectives to improve the health and well-being of patients and provide good quality care contained in their statement of purpose. The practice values, vision and goals were discussed with staff at their induction. Examples of the practice vision and values included

providing high quality, safe, professional services to patients, prevention of disease by promoting health and wellbeing, and offering care and advice to patients. GPs told us that this was achieved by working in partnership with patients, their families and carers. Members of staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Management staff had a clear business plan for the next year, where they identified the main issues and how they intended to address these for the next year. Staff had specific individual objectives via their appraisal which fed in to these, such as clinical staff looking to develop their knowledge in a certain area to be able to offer additional service.

Governance Arrangements

Staff were clear on their roles and responsibilities, and felt able to communicate with doctors or managers if they were asked to do something they felt they were not competent in. The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared computer system, which logged who had read reports. All the policies and procedures we looked at, such as chaperone policy, Mental Capacity Act policy and human resources policies had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. All GP partners had additional areas of responsibility, for instance, safeguarding. Monthly management meetings were held and other staff given the opportunity to comment on decisions taken by managing partners.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for PMG showed it was performing in line or above national standards. The practice regularly reviewed its results and how to improve. The practice had identified lead roles for areas of clinical interest, safeguarding, or management tasks, and had a coherent strategy and aims for the future. There was a programme of clinical audit, subjects selected from QOF outcomes, from the CCG, following an incident or from the GP's own reflection of practice. Audits on subjects such as prescribing of medicines for heart patients, and use of an anti-inflammatory medicine.

The practice audited many areas monthly, including call waiting times, time taken to process correspondence, and time taken to process referrals. The practice had arrangements for identifying, recording and managing risks. A risk log was kept, which addressed a wide range of potential issues, such as the environment and infection control. We saw that the risks identified were discussed at team meetings and updated in a timely way. The practice held regular practice meetings. We looked at the minutes from the meetings over the last year and found that performance, quality and risks had been discussed.

From our discussions with staff we found that they looked to continuously improve the service being offered, and valued the learning culture. We saw evidence that they used data from various sources including incidents, complaints and audits to identify areas where improvements could be made.

Leadership, openness and transparency

Staff said they felt happy to work at the surgery, and that they were supported to deliver a good service and good standard of care. Staff described the culture at the practice as open and honest, and said they felt confident in raising concerns or feedback.

There was a clear chain of command and organisational structure. Staff described communication as generally good, and said it was easy to escalate issues if necessary.

There was a Human Resource (HR) manager who had responsibility for HR management across the PMG group. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We saw that these were well laid out and easy to understand. We were shown the electronic staff handbook that was available to all staff, which included sections on areas such as equality, and

Are services well-led?

Good

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

harassment and bullying at work. The handbooks were also tailored to the different staff roles such as GPs and administration staff. Staff we spoke with knew where to find these policies if required.

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

There was an active Patient Reference Group (PPG), which met on average monthly. Annual patient survey reports and action plans were published on the practice website for the practice population to read. The practice was actively advertising to recruit to the group to ensure it was representative of the practice population.

The practice had gathered feedback from patients through patient surveys, two minute surveys and complaints received. We saw that following comments received the PMG had undertaken a comprehensive restructure of how phone calls were answered in a timely manner. This resulted in the creation of a new team of staff dedicated to handling patient calls. We saw that following the annual surveys priority areas were agreed with the PPG and these formed the basis of the initial practice objectives. Examples of these were to improve communication with patients, improve access to appointments and explain the surgery appointment system clearly for patients.

Staff told us they felt confident giving feedback, and this was recorded through staff meetings. Staff told us they generally felt involved and engaged in the practice to improve outcomes for both staff and patients. There was a whistleblowing policy which was available to all staff.

Management lead through learning & improvement

Staff told us the practice supported them to maintain their clinical professional or personal development through training and mentoring. We saw that appraisals took place where staff could identify learning objectives and training needs.

The practice was a training practice and supported medical students and a GP registrar at the time of inspection. There was also an in-house education programme which staff could access. The practice had completed reviews of significant events and other incidents. Staff told us the culture at the practice was one of continuous learning and improvement.