

# Tollerton Surgery

## 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?

Requires improvement



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

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Tollerton Surgery on 4 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the population groups of older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable, people experiencing poor mental health (including people with dementia). It required improvement for providing safe services. Although we have rated the safe domain as requires improvement, there was no evidence that this had impacted on the care of patients in the population groups.

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

- There were always enough staff on duty to keep patients safe.
- The GPs and nursing staff were familiar with current best practice guidance, accessing supporting information from the National Institute for Health and Care Excellence (NICE) and from local commissioners.
- Most patients said all staff were helpful, supportive and caring.
- The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.
- The practice had a three year business plan in place which set out the practices objectives.

We saw one area of outstanding practice:

- The practice had admitting rights, along with two other practices, to a local hospital which offered community beds for palliative care and geriatric care admissions. All GPs at the practice carried out ward

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visits at this hospital which provided continuity of care for patients. They also worked in conjunction with other health care professionals to deliver the services at this hospital.

However, there were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that required pre-employment checks are completed before staff commence work.

The provider should:

- Ensure that records relating to controlled drugs are appropriately stored and updated in timely way.
- Ensure that systems are in place to ensure the security of patient records when outside of the practice.
- Ensure arrangements are in place for the monitoring of all high risk medicines.
- Ensure that a plan is put in place to address the identified infection control issues, such as inappropriate flooring, loose tiling and damaged work surfaces.

**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 practice is rated as requiring improvement for providing safe services. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice had some systems in place to identify risks and improve patient safety. These included systems for reporting incidents, acting on national patient safety alerts and responding to comments and complaints received from patients. There were policies and protocols for safeguarding vulnerable adults and children and any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible. The safeguarding lead GP had completed training in safeguarding children and adults. Despite this we found that staff were not always recruited safely and some staff had commenced work prior to a police check or risk assessment being completed. Although we have rated the safe domain as requires improvement, there was no evidence that this had impacted on the care of patients in the population groups.

Requires improvement



### Are services effective?

The GPs and nursing staff were familiar with current best practice guidance, accessing supporting information from the NICE and from local commissioners. Staff were skilled in specialist areas and best practice guidance was considered. The practice offered national screening programmes including dementia screening, sexual health advice, vaccination programmes, long term condition reviews and provided health promotion information to patients. The practice also participated in a number of initiatives which included the 'Alcohol related risk reduction scheme' and 'Avoiding unplanned admissions'.

Good



### Are services caring?

The practice is rated as good for providing caring services. Most patients said all the staff were helpful, supportive and caring. They said staff treated them with dignity and respect. Information was made available to patients to sign post them to other support services and organisations, and records showed the practice responded appropriately to complaints received. We observed staff treating patients in a person centred, dignified and professional way. Staff were mindful of maintaining patient confidentiality at all times.

Good



### Are services responsive to people's needs?

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs

Good



# Summary of findings

of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had joined the York Federation in order to try to improve the delivery of services to its patients. Patients were generally satisfied with the appointments system.

## Are services well-led?

The practice is rated as good for being well-led. The practice had a three year business plan in place which set out the practices objectives. Staff were clear about the vision and their responsibilities in relation to this although some staff told us they would benefit from improved communication in relation to all aspects of the business plan; particularly relating to the planning of new premises. There was a leadership structure and most staff felt supported by management. There were arrangements in place to monitor and improve quality and identify risk, although there were limited records to confirm these arrangements. The practice had a patient participation group (PPG) in place. Staff had received inductions, regular performance reviews and attended staff meetings and events.

**Good**



# 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

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and offered a range of enhanced services, such as minor surgery, dementia screening and a range of additional vaccinations. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had admitting rights, along with two other practices, to a local hospital which offered community beds for palliative care and geriatric care admissions. All GPs at the practice carried out ward visits at this hospital which provided continuity of care for patients. They also worked in conjunction with other health care professionals to deliver the services at this hospital. Patients in nursing and residential care were seen by a named GP and offered services in the home. All patients over 75 years of age had a named GP and a care plan. The practice had signed up to the reducing unplanned admissions scheme and was actively monitoring this. Immunisations were offered to this group of patients; for example shingles. Flu vaccination uptake rates were equal or slightly higher than the national average for patients over 65 years or at risk.

Outstanding



### People with long term conditions

The practice is rated as good for the care of patients with long-term conditions. 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. Clinical staff specialised in areas such as COPD, Diabetes and Asthma. All patients had a care plan in place which was regularly reviewed. The practice demonstrated they had acted on feedback from professionals to improve the outcome for patients in this group. Nationally reported data showed the practice was proactive in identifying and monitoring patients with long-term conditions and performed well above the national average in a number of areas. For example, COPD diagnosis and diabetes monitoring.

Good



### Families, children and young people

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 who were at risk, for example, children and young people who had a high number of A&E attendances. The practice offered a

Good



# Summary of findings

full range of immunisations for children. Immunisation rates of children who were eligible for immunisations at aged 12 months, 24 months and five years was comparable to other practices in the CCG area.

Appointments were available outside of school hours. Facilities within the premises were not fully adapted to accommodate babies; for example, there was no baby changing facility or breast feeding area available. The practice worked jointly with the community midwife and health visitor. The practice offered weekly midwife led clinics and monthly health visitor clinics. Joint working with these professionals involved immunisation and post natal checks being co-ordinated in response to health visitor feedback. The practice offered sexual health services and participated in the 3Cs and HIV programme. This is designed to strengthen sexual health work. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

## **Working age people (including those recently retired and students)**

The practice is rated as good for the population group 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 to ensure these were accessible, flexible and offered continuity of care. The practice offered extended appointments on a Monday from 7:15am and a Wednesday from 7:30am. However, the practice closed between 1pm and 2pm daily. 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 the practice was actively promoting health checks for these patients.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. It carried out annual health checks for people with a learning disability either at the practice or in their home and engaged with a local care home to ensure specific needs of their patients were being met. The practice offered longer appointments for people with a learning disability. The practice held a register of vulnerable patients who may be at risk of unplanned admissions and all these patients had a care plan in place. The practice managed the dosage of certain medicines for patients who were housebound.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and staff demonstrated

Good



# Summary of findings

knowledge of those people. Staff knew how to recognise signs of abuse in vulnerable adults and children and was aware of these patients. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

## **People experiencing poor mental health (including people with dementia)**

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had established links with multi-disciplinary teams in the case management of people experiencing poor mental health. A mental health practitioner (CPN) attended the practice weekly and worked with patients with conditions such as anxiety and depression. They also provided cognitive behavioural therapy (CBT) when required. The practice carried out dementia screening as part of their enhanced services. The practice had a number of patients with alcohol problems and worked closely with the alcohol support team and had engaged in an alcohol reduction scheme. Nationally reported data showed the practice performed well above the national average for health checks for patients with a mental illness and assessment of depression severity.

**Good**





# Summary of findings

## What people who use the service say

We spoke with six patients who were using the service on the day of our inspection and reviewed 19 completed CQC comment cards. The majority of feedback from patients was positive. Patients described the practice and staff as helpful, very good and respectful.

National GP survey results published in July 2014 indicated that the practice was best in the following areas when compared to the local CCG average:

- 96% of respondents described their overall experience of this surgery as good.
- 97% of respondents were able to get an appointment to see or speak to someone the last time they tried.
- 82% of respondents usually wait 15 minutes or less after their appointment time to be seen.

The national GP survey results published in July 2014 indicated that the practice could improve in the following areas when compared to the local CCG average:

- 84% of respondents found the receptionists at this surgery helpful
- 72% of respondents are satisfied with the surgery's opening hours
- 81% of respondents would recommend this surgery to someone new to the area

There were 249 surveys sent out, 116 returned giving a completion rate of 47%.

## Areas for improvement

### Action the service **MUST** take to improve

The practice must ensure that effective pre-employment checks are carried out prior to staff commencing work.

### Action the service **SHOULD** take to improve

The practice should ensure that records relating to controlled drugs are appropriately stored and updated in timely way.

The practice should ensure that systems are in place to ensure the security of patient records when outside of the practice.

The practice should ensure arrangements are in place for the monitoring of all high risk medicines.

The practice should ensure that a plan is put in place to address the identified infection control issues, such as loose tiling and damaged work surfaces.

## Outstanding practice

The practice had admitting rights, along with two other practices, to a local hospital which offered community beds for palliative care and geriatric care admissions. All

GPs at the practice carried out ward visits at this hospital which provided continuity of care for patients. They also worked in conjunction with other health care professionals to deliver the services at this hospital.

# Tollerton 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 GP and a practice manager.

## Background to Tollerton Surgery

Tollerton Surgery, 5 – 7 Hambleton View, Tollerton, North Yorkshire, YO61 1QW is situated in a rural area outside York. The registered patient list size of the practice is 3,310. The overall practice deprivation is on the least deprived decile.

Staffing at the practice was as follows:

GP Partners = 2

Salaried GP = 1

Practice Manager = 1

Nurse Practitioner = 1

Practice Nurse = 1

Healthcare Assistant = 1

Dispenser = 4

Reception/Admin = 4

Admin = 1

Cleaner = 1

The practice has a general medical service (GMS) Contract under section 84 of the National Health Service Act 2006.

The CQC intelligent monitoring placed the practice in band 6. 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.

Tollerton Surgery is a teaching partner with Hull and York Medical School providing placements and teaching for fifth year medical students. The practice does not currently have a student working at the practice.

The practice has opted out of providing out-of-hours services to their own patients. Patients use the 111 service when the practice is closed.

## 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.

This provider had not been inspected before and was selected at random from the Clinical Commissioning Group (CCG) area.

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. These groups are:

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

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 4 December 2014. During our visit we spoke with a range of staff; the two GP partners, practice prescribing nurse, health care assistant, practice manager, pharmacist, dispensers and administrative staff. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

# Are services safe?

## Our findings

### Safe track record

The practice had some systems in place to identify risks and improve patient safety. These included systems for reporting incidents, acting on national patient safety alerts and responding to comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed the significant event records and found these had been managed consistently over time. Staff told us incidents and risks were discussed at staff meetings although we were unable to confirm this, as limited records of staff meetings were available.

We found staff were not always recruited safely and some clinical staff had commenced work prior to a police check being completed.

The practice did not have a system in place for reviewing all significant events over a period of time to look at trends and the success of changes introduced.

### Learning and improvement from safety incidents

The practice had a system in place for reporting and recording all significant events, incidents and accidents and all staff were aware of this. We saw significant events were recorded and records showed the practice had learned from these incidents, had been reviewed with staff, mitigating actions put in place and the actions reviewed at a later date. For example the practice had introduced a triage system to reduce the number of telephone interruptions to the dispensing staff as this had been identified as a potential reason why errors were being made. All staff knew how to raise an issue for consideration at practice meetings and felt confident and encouraged to do so; although some reported a lack of confidence in always being listened to. However, we found that only significant events relating to prescribing were monitored and analysed over time.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke to were able to give examples of recent alerts that were relevant to the care they were responsible for. We saw examples of

action the practice had taken in response to safety alerts. For example, we saw a new standard operating procedure (SOP) for a certain pain relieving medicine had been read by all staff and the relevant action taken.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. The safeguarding lead GP had completed training in safeguarding children and adults. All other staff had completed training in safeguarding children but not adults. All staff we spoke to were aware of the lead and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. Staff told us about the systems they had in place for monitoring vulnerable patients. For example; identifying children with a high number of A&E attendances and following up children who failed to attend appointments for childhood immunisations. Clinical staff acted as chaperones and there was a chaperone policy visible in the waiting room.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Staff described the policy for ensuring that medicines were kept at the required temperatures and what action to take in the event of a potential refrigeration failure. The practice was able to describe a recent significant event and the appropriate action they had taken following a refrigeration failure in the days prior to the inspection.

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.

## Are services safe?

Vaccines were administered by the practice nursing team using protocols that had been produced in line with legal requirements and national guidance. We saw evidence that the practice nursing team had received appropriate training to administer vaccines. A member of the nursing staff was qualified as a nurse prescriber and they received regular supervision and support in their role, as well as updates in the specific clinical areas of expertise for which they prescribed. The nurse prescriber and pharmacist told us they had established good working relationships with the CCG medicines management team. We saw evidence of specific medication audits completed and changes in the use of medicines in response to input from the medicines management team. For example a review of patients using certain drugs used for the management of hypertension. We were told that prescribing was monitored using Prescribing analysis and cost tabulation (PACT) data and also information from the medicines management team.

There were arrangements in place for the management of some high risk medicines; mainly Methotrexate and records showed this was managed appropriately. However, such close monitoring arrangements were not in place for other high risk medicines.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These drugs were stored appropriately and arrangements were in place for the destruction of controlled drugs. The pharmacist had systems in place for monitoring stock levels of CDs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. However, we identified two issues relating to the management of CDs. We were told that CDs were not always recorded into the practice in a timely way and as the practice was using a ring binder style system for recording CDs that some of the records had been removed and misfiled.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw that this process was working in practice. We observed medicines being dispensed and saw arrangements were in

place to minimise dispensing errors. Records showed dispensing errors were recorded and reviewed to reduce the risk of errors being repeated. Dispensing staff authorised repeat drugs only when a review was not required. Where a review was required systems were in place to arrange a review with the GP. The GP SPA looked at anonymised patient notes and saw that medication reviews were managed appropriately. All members of staff involved in the dispensing process had received appropriate training and their competence was regularly checked.

### Cleanliness and infection control

We observed the premises to be clean and tidy. Patients did not raise any concerns regarding the cleanliness of the practice.

The practice had a lead for infection control who had undertaken recent training to enable them to provide advice on the practice infection control policies. The practice acknowledged they were not completing infection control audits and had identified this as an area for development following the recent training attended by the infection control lead. We saw evidence that some work in this area had begun. For example a protocol for cleaning the spirometer and ear syringe machine had been put in place.

Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Sharps bins were available and used. Bins with lids and foot pedals for the disposal of general and clinical waste were in place. Special kits to be used in the event of a spillage of blood or body fluids were available and stored appropriately. A needle stick injury policy was in place. Hand wash and safe hand washing guidance was displayed in treatment rooms. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

## Are services safe?

We looked in the clinical areas at the practice. We noted unsuitable flooring in the treatment and nurse's room, and noted loose tiling on window sills, masking tape to repair a damaged work surface and no sealant around sink and draining areas. There was no action plan available to show when these issues would be addressed. The practice business plan showed the practice was in the initial stages of exploring the possibility of new premises.

### Equipment

There was a range of medical equipment at the practice, which included an electrocardiogram (ECG), spirometer and defibrillator. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Arrangements were in place for testing and calibrating equipment. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of equipment such as spirometer, defibrillator, vaccine fridge and 24 hour blood pressure machine.

### Staffing and recruitment

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. They told us about the arrangements for planning and monitoring the number of staff and mix of staff to meet patients' needs.

The practice had a recruitment policy in place but this was not always being followed. Records we looked at contained evidence that some recruitment checks had been undertaken prior to employment. For example, proof of identification, references and employment history. However, the practice had not ensured that criminal records checks through the Disclosure and Barring Service (DBS) were carried out in a timely way for some clinical staff which meant some clinical staff commenced work prior to a DBS check. We also found that dispensing staff did not have a DBS check or a risk assessment in place to show the practice had risk assessed why dispensers should not have a DBS check. Clinical staff were responsible for ensuring their professional registrations were up to date. Despite this, the practice did not have arrangements in place to assure them that the clinical staffs' professional registrations were up to date with the relevant professional bodies.

### Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing and equipment. However, as noted above the practice had not identified and recorded risks relating to other areas such as the environment and infection control. The practice had a health and safety policy. Health and safety information was available for staff and there was an identified health and safety representative.

The practice did not keep a central log of identified risks. We were told that clinical staff met weekly and that risks were managed and dealt with as soon as they arose. Clinical staff told us risks were discussed in a timely and appropriate way. We were provided with a detailed example of a recent significant event relating to the refrigeration of medicines and how the practice had responded to the risk. However, there were limited records kept at the practice which staff could refer to at a later date.

### Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage most emergencies. Records showed that all staff had received training in basic life support, although this did not include recent training in emergency first aid such as anaphylaxis. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The GPs also had access to a portable defibrillator.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines for use within the practice were within their expiry date and suitable for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, unplanned sickness and access to the building. The document also contained a range of contact details for staff to refer to. However, staff at the practice did not have access to the emergency numbers when not in the office.

## Are services safe?

The practice had a designated fire warden to assist in the evacuation of the practice in the event of an emergency. Records showed that staff were up to date with fire training

and that they practised regular fire drills. There was no information displayed within the practice about what action to take to evacuate the building in the event of an emergency.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, accessing supporting information from the NICE and from local commissioners. Staff were skilled in specialist areas which helped them ensure best practice guidance was always being followed. Staff told us they discussed new guidance, patients, and the practice's performance at clinical meetings. They also said that each patient was given support to achieve the best health outcome for them. We also found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. We were only able to review a limited amount of records to confirm these discussions as the practice did not routinely record clinical meetings.

Staff we spoke with and the evidence we reviewed demonstrated that there were appropriate clinical and nursing leads in specialist clinical areas such as diabetes, heart disease and asthma which allowed the practice to focus on specific conditions. The practice had management plans in place to support those patients with long term conditions such as asthma, diabetes and chronic obstructive pulmonary disease (COPD).

The practice had systems in place for monitoring the needs of patients and mechanisms for encouraging patients to attend for routine reviews, for example the annual health checks and cervical smears. There were also systems in place for reviewing patients who had recently been discharged from hospital and who had changes in their medication. The practice acknowledged they needed to improve their arrangements for the recall of patients to the practice and had started to put measures in place to address issues. For example, designated time had been allocated on a regular basis to carry out reviews of patients at a local care home. Despite this acknowledgement the general practice high level indicators (GPHLI) and the Quality Outcome Framework (QOF) data showed the practice was performing well in a wide range of areas. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

### Management, monitoring and improving outcomes for people

Staff at the practice had key roles in monitoring and improving outcomes for patients. The practice showed us two examples of completed audit cycles that had been undertaken in the last 12 months. These were audits of patients using the medicine Methotrexate and also Combined Oral Contraceptive Pill (COCP) users. These audits showed resulting positive outcomes for patients and effective management by the practice. Other audits were also seen, which included an audit of the functionality of the dispensary and patients using the medicine warfarin.

We were told clinical audits were often linked to medicines management information, safety alerts, and information within the practice or as a result of information from the QOF. For example, we saw an audit of stroke prevention in Atrial Fibrillation with oral anticoagulation therapy which had been carried out following recent guidance. The audit showed the practice was following good practice in terms of monitoring and advising patients regarding warfarin control when compared to the information from the British Heart Foundation. The audit also showed the practice had taken action to strive towards achieving the Gold standard of 100% in a particular area relating to this audit.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had achieved an overall QOF score of 99.7%.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question.

When available, the practice also participated in local benchmarking. This is a process of evaluating performance



# Are services effective?

## (for example, treatment is effective)

data from the practice and comparing it to similar surgeries in the area. For example the practice used the CCG information relating to unplanned admissions to compare the practice's performance against other practices in the area. The practice also met regularly with members of the Vale of York GP Federation where performance was discussed and compared.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We noted a good skill mix among the staff group with staff having a range of qualifications and experience. For example all the GPs had a Diploma of the Royal College of Obstetricians and Gynaecologists. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The majority of staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice provided training and funding for relevant courses. However, we were told that the practice manager was not appraised and not all staff had protected learning time.

Clinical staff were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, records showed staff had completed training in areas such as cervical cytology, spirometry, foot pulses and the administration of vaccinations. We were told by staff that they were not expected to complete roles outside of those tasks they had been assessed or trained as being competent to do. Those with extended roles, for example running clinics for patients with long-term conditions such as asthma and diabetes were also able to demonstrate that they had completed training to enable them to fulfil these roles.

### Working with colleagues and other services

The practice was part of the Vale of York GP Federation. The federation was made of 13 other GP practices who worked together on a range of areas to improve services for patients. The practice had signed up to provide enhanced services in 2014 and 2015. This included providing

additional services such as minor surgery, dementia screening and a range of additional vaccinations. Records showed the practice was keeping these areas under review and submitting the required data returns to the CCG.

Clinical staff told us the practice had well established multi-disciplinary working arrangements in place to meet people's needs and manage patients with complex health needs. However, there were no records kept to confirm these arrangements. The practice had admitting rights, along with two other practices, to a local hospital which offered community beds for palliative care and geriatric care admissions. All GPs at the practice carried out ward visits at this hospital which provided continuity of care for patients. They also worked in conjunction with other health care professionals to deliver the services at this hospital. The practice also worked closely with other services such as health visitors, district nurses, Child and Adolescent Mental Health Services (CAMHS), nursing and residential homes, hospices and bereavement services. The practice also participated in the local CCG referral arrangements for patient referrals, which they said was beneficial to patients. A mental health practitioner (CPN) ran regular sessions at the practice. One member of staff told us about the links they had established with York diabetes clinic. The practice also engaged the services of the local Clergy.

### Information sharing

There was effective communication and information sharing and decision making about a patient's care across all of the services involved both internal and external to the practice. For example, there was a shared system with the local GP 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, and the practice made 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 in discussion with their chosen hospital). The practice 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 both electronically and by post. Staff were clear about their role in managing information that came into the practice to ensure it was managed in a timely and effective way.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

# Are services effective?

(for example, treatment is effective)

record to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice told us that patients' paper records were stored in secure off-site storage. However, we found that the practice did not have suitable arrangements in place to ensure records were transferred back to the practice in a secure way.

## Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and was able to describe how they implemented it in their practice.

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. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. We saw that end of life decisions were discussed and appropriately recorded. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions, such as minor surgery which practice staff followed.

## Health promotion and prevention

The practice had a range of information available for patients displayed in the patient waiting area and on the practice website relating to health prevention and

promotion. This included information on sexual health, children's health, long term conditions such as asthma, information for people who suffer from mental ill health and learning disabilities, and general health promotions that included smoking cessation and alcohol awareness.

New patients registering with the practice completed a health questionnaire and were given a new patient medical appointment. This provided the practice with important information about their medical history, current health concerns and lifestyle choices. The practice assessed the patients' individual needs to ensure support and treatment was available as soon as possible.

The practice offered national screening programmes including dementia screening, sexual health advice, vaccination programmes, long term condition reviews and provided health promotion information to patients. The practice also participated in a number of initiatives which included the Alcohol related risk reduction scheme and Avoiding unplanned admissions. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. Staff were knowledgeable about the practice populations health issues and the changing demographic and staff used their knowledge to adjust the health advice and multi-disciplinary working accordingly.

The practice's performance on the GPLH showed the practice was performing above the national average in a number of areas. Examples of this included; Diabetes blood pressure and HbA1C monitoring; cervical smears; Flu vaccinations for over 65's and those patients at risk; health checks for mental illness and assessment of depression severity

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. Of the respondents the evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 96% described their overall experience of the surgery as good. The data showed that for consultations with GPs and nurses that 95% said the GP and 98% said the last nurse they saw was good at listening to them. Of the respondents, 91% said the GP and 97% said the last nurse they saw or spoke to was good at treating them with care and concern.

The majority of completed CQC comment cards were positive about the service experienced. Patients said they felt the practice offered an efficient and helpful service. Patients described staff as helpful, kind and supportive. They said staff treated them with dignity and respect. Two comments were less positive but these related to issues that have now been addressed by the practice following feedback from patients. Patients on the day of the inspection told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We observed patients being treated with dignity and respect as they arrived at the practice and as they were called and escorted to their appointments. There was a relaxed, person centred, professional interaction between patients and staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were used in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation/ treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Despite this we observed that due to the small size of the reception area that telephone discussions and discussions with patients could be overheard in the reception area, although only some patients raised this as an issue.

Patients and staff told us the practice was aware of this issue and were sensitive about the conversations they had with patients. We were told by the practice that a separate room for discussions could be used if needed.

### **Care planning and involvement in decisions about care and treatment**

Nationally reported data showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89% of practice respondents said the GP involved them in care decisions and 91% felt the GP was good at explaining treatment and results. The practice's own satisfaction survey carried out in February 2014 did not report any findings in this area.

Patients told us that health issues were discussed with them and they felt involved in decision making and well informed about the care and treatment they received. Where applicable patients told us they were involved in choosing which hospital they would attend for further treatment. Patient feedback on the CQC comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language as well as accessing one of the GPs who spoke Polish. The practice told us they assessed the most suitable way of communicating with patients. There was no information on the practice website about translation services available to patients.

### **Patient/carer support to cope emotionally with care and treatment**

The patients we spoke to on the day of our inspection told us that staff responded compassionately when they needed help, and provided support when required. Staff told us they provided an empathetic and person centred service to their patients.

The practice provided information and support to patients who were bereaved and for carers. The practice provided literature and signposting to support groups, advocacy services and organisations within the practice. They also liaised with the local Clergy. The practice maintained a list of carers and they were offered health support and advice.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice was responsive to people's 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 in the way services were delivered. The practice had joined the Vale of York Federation in order to try and improve the delivery of services to its patients.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice participated in providing data returns to the CCG and used this information to monitor and improve their performance. For example the practice had submitted actions plans to the CCG to reduce unplanned admissions to secondary care.

### Tackling inequity and promoting equality

The practice utilised various techniques to communicate with patients. Staff told us how they assessed the most appropriate way to communicate with patients.

The practice did not provide specific equality and diversity training for staff; although staff were clear that all staff were treated equally. We saw no evidence of discrimination when making care and treatment decisions. Interviews with the clinical staff demonstrated that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

The practice was situated on the ground floor and was accessed via steps or ramped access. However, we noted there was no outside doorbell for patients to use who may require assistance with opening the front door or the doorway from reception to the waiting area. The entrance hallway and doorway into the waiting area was narrow with no handrails for patients to use and patients in wheelchairs or with prams could experience difficulty opening the doors. The toilet did not have any baby changing facilities and there were no breast feeding facilities available for patients although we were told that a room would be made available if needed. Access to the patient toilet was partially restricted by a chair and the toilet was small and not fully adapted. Seating in the waiting area was bench

style; all of one height and size which meant there was no variation for diversity in physical health. No audio loop was available for patients. The practice told us this was not an issue as they were aware of patients with hearing difficulties and communicated with these patients accordingly. The practice was aware of the issues relating to the suitability of the practice and were in the initial stages of exploring the possibility of new premises. No concerns were raised by patients about accessibility to the practice.

### Access to the service

The practice was routinely open from 8am to 6.30pm four days a week and 8am until 4pm one day a week. The practice closed between 1pm and 2pm Monday to Friday. The practice offered extended appointment times with pre-bookable appointments available from 7.15am on Mondays and 7.30am on Wednesdays. The GP national survey showed the percentage of patients who were 'Very satisfied' or 'Fairly satisfied' with their GP practice opening hours was 72.4% compared to the national average of 79.8%.

Information was available to patients about appointments on the practice website. This included how to book appointments via the surgery and the practice website and how to request a GP home visit. Information to ensure patients received urgent medical assistance when the practice was closed was available to patients on the practice website. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Patients were sent reminders about appointments by text message.

The national GP survey results published in July 2014 showed that 97% of patients were able to get an appointment to see or speak to someone the last time they tried. 93% said the last appointment they got was convenient. 83% of respondents found it easy to get through to the surgery by phone. 84% of patients said they found the receptionists helpful. 79% described their experience of making an appointment as good. We saw evidence that the patient participation group had requested additional pre-bookable appointments to be made available following feedback from patients and this had been actioned.

# Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Follow up appointments were made during consultations. When appropriate, home visits were made to a local nursing home by a named GP to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

## **Listening and learning from concerns and complaints**

Patients we spoke with said they would speak with a member of staff if they needed to make a complaint. None

of the patients we spoke with had ever needed to make a complaint about the practice. The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We looked at the ten complaints received since January 2014 and found these were handled satisfactorily and had been dealt with in a timely and person centred way. Each person was contacted by the practice to try and reach a satisfactory outcome for the complainant. There was no information displayed within the practice to tell people how to make a complaint direct to the practice or to any other organisations such as NHS England and there was no complaints/suggestions box for patients to complete in the waiting area.

# 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 mission statement was “To provide an efficient and personalised package of care to our patients whenever they need our support”. The practice had a business plan in place for the period of 2014 to 2016 that set out the practices objectives over the next three years. These included; planning for new premises, membership of the York federation, providing enhanced services and being part of the dispensary services quality scheme. During the course of the inspection we found that these areas had either been achieved or were in various stages of progress.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in paper format. We looked at 10 of these policies and all had been reviewed and were up to date. Staff were aware of the policies and procedures in place although the practice did not have a system for monitoring that staff had read them.

There was a leadership structure with named members of staff in lead roles. For example, there was an information governance, safeguarding and infection control lead. There were lead nurses for specific long term conditions. All staff were clear about their own roles and responsibilities and those of their colleagues. Most staff told us they felt valued and supported. All staff knew who to go to in the practice with any concerns.

We were told the practice had arrangements in place for completing clinical audits and monitoring against the QOF, LES (Local Enhanced Services) and DES (Direct Enhanced Services) which were used to monitor quality and performance of the practice.

The practice had arrangements for identifying, recording and managing risks. All the staff we spoke with told us that any issues were discussed at the weekly clinical meeting. The practice did not routinely record the discussions of these meetings and therefore we were unable to confirm from the records what was discussed. However, we did see some minutes which showed that risks to patients were discussed and actions put in place to mitigate the risk. For example; where a patient with a long term condition had declined to have a care plan. The practice staff told us that they did not hold formal multi-disciplinary recorded

meetings but that the current arrangement for inviting other professionals to their clinical meeting worked well. The practice recognised the need for more formal recording of meetings.

### Leadership, openness and transparency

The practice had a leadership structure in place. Staff had been allocated lead roles; for example the practice manager led on information governance, a GP on safeguarding and a nurse on infection control. All staff were clear about their own and their teams roles and responsibilities.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example sickness management and disciplinary, which were in place to support staff. A staff handbook was made available to staff.

Staff told us the clinical meetings and information sharing at the practice helped them keep up to date with most developments and any issues. However, we were told by some staff that the practice staff would benefit from a full staff practice meeting so that all staff could meet together. Staff told us they were encouraged to have a voice, although some felt this was not always listened to. We were told that team meetings took place but there were limited records available to confirm the discussions that took place.

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

The practice had gathered feedback from patients through staff meetings, patient surveys, significant events and complaints received. We saw the practice had taken action as a result of patient and public feedback.

The practice had an active patient participation group (PPG). The last patient survey was considered in conjunction with the PPG and actions put in place. The annual PPG report for 2014 was available on the practice website.

The practice did not formally gather feedback via a staff survey but staff were encouraged to provide feedback in other ways; for example through staff meetings, appraisal and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management, although some staff felt that



# Are services well-led?

Good 

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

they were not always listened to or their issues considered by some members of staff. Most staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to develop through training and mentoring, although some staff told us they did not have protected time to do this and had to complete training in their own time. Staff completed training in most areas applicable to their role. However, we found that staff had not completed training in some areas, such as safeguarding adults and being able to respond to

an emergency. Staff told us the practice encouraged learning and improvement through meetings and through staff appraisals. We saw most staff received regular appraisals.

The practice is a teaching partner with Hull and York Medical School. It has a lead GP for providing placements and teaching for fifth year medical students. Arrangements were in place for managing appointments with trainee GPs to ensure they received the appropriate support.

The practice had joined the York Federation to work with other local practices to address the challenges facing general practice and to develop new services in primary care.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers  <b>The practice did not operate effective recruitment procedures which ensured staff were fit to undertake their role.</b>
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	