# Collingham Church View Surgery

## Quality Report

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Collingham Church View Surgery on 23 July 2015. The practice achieved an overall rating as good.

Specifically, we rated the practice as good for providing safe, effective, caring, responsive and well-led services and care for all of the population groups of people it serves.

Our key findings were as follows:

- Feedback from all patients we spoke with and comments we received were overwhelmingly positive about the practice and the care they received. Patients said they were treated with compassion, dignity and respect and were involved in care and decisions about their treatment. Information was provided to help them understand the care that was available.
- The practice worked closely with other organisations and local care providers in planning how services were provided to ensure they met the needs of patients.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The practice used the Year of Care approach to provide personalised care planning for patients who had a long term condition.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.
- There was a clear leadership structure and staff felt supported by management. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- The practice had a clear vision and direction, with quality service delivery, patient care and safety as its priority.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

We found two areas of outstanding practice:

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- The practice had purchased a slit lamp (specialised equipment used to microscopically examine the eye for any abnormalities). This enabled one of the GPs, who was trained in ophthalmology (specialism in eye problems), to undertake eye screening on appropriate patients. This had reduced the need for referral of these patients to hospital.
- The practice had purchased a dermatoscope (specialised equipment used to examine skin lesions more closely). This had been used in early detection of malignant and benign skin lesions It had also reduced unnecessary hospital referrals and skin surgery.

However, there were two areas of practice where the provider should make improvements:

- The practice should ensure all clinical and non-clinical staff are involved in practice meetings and clinical meetings, as relevant, to support learning, integration and a cohesive approach to service delivery and patient care.
- Review the process for the dispensary accepting medicines ordered from suppliers to ensure the medicines they received were in date and thereby effective.

**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 good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and disseminated to staff. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed. Patients who were identified as being at risk were monitored and the practice worked with other agencies to safeguard children, young people and adults whose circumstances may make them vulnerable. There were enough staff to keep patients safe. The premises were clean and well maintained and risks of infection were assessed and managed. There were processes in place for safe medicines management. However, the process for the dispensary accepting medicines which had been ordered from suppliers needed reviewing, to ensure all were in date upon receipt and thereby effective.

**Are services effective?**

Good

The practice is rated good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified through the use of annual appraisals. Staff worked with multidisciplinary teams to provide effective care and support to patients. The practice used the Year of Care approach to provide personalised care planning for patients who had a long term condition. (This approach supports patients to self-manage their own care, in conjunction with health professionals, and the actions they want to take to improve their health and well-being.)

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice highly for several aspects of care in comparison to other practices in the locality. Patients who responded on CQC comment cards and those we spoke with during our inspection said they were treated with compassion, dignity and respect. They spoke very highly of the practice and told us they were

# Summary of findings

involved in decisions about their care and treatment. Care planning templates were available for staff to use during consultation. We observed staff treated patients with kindness, respect and ensured confidentiality was maintained.

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

Good

The practice is rated good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team, Leeds North Clinical Commissioning Group (CCG) and other local GP practices to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system and evidence showed the practice responded quickly to issues raised and learning from complaints was shared with staff. Urgent appointments were available on the same day as requested and pre-bookable appointments were available three months in advance.

**Are services well-led?**

Good

The practice is rated good for providing well-led services. It had a clear vision and strategy and staff were clear about their roles and responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the GPs and manager. The practice had a number of policies and procedures in place. While there were regular practice meetings, not all clinical staff were included in these. Furthermore, general staff meetings were infrequent. Staff inclusive meetings ensure information and risk are managed more effectively. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from patients through the use of the NHS friend and family test and patient surveys. There was an active patient participation group who regular engaged with the practice.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP. The practice was responsive to the needs of older people, offering home visits and longer appointments as needed. The practice worked closely with relevant health and social care professionals to deliver a multidisciplinary package of care. They also worked with voluntary services, such as Wetherby in Support of the Elderly (WISE) and the Home from Hospital Service operated by the Red Cross, to support older people to live independently in their own homes.

**People with long term conditions**

Good

The practice is rated good for the care of people with long term conditions. The GPs and nursing staff had lead roles in chronic disease management such as diabetes and respiratory conditions. Longer appointments and home visits were available when needed. Patients were offered a structured annual review, around the date of their birthday, to check their health and medication needs were being met. The practice used the Year of Care approach to provide personalised care planning for patients who had a long term condition. 'One stop' clinics were available for patients who had more than one long term condition, to prevent the need for multiple appointments.

Wetherby Health Centre, in conjunction with four local practices, had co-funded the employment of three additional nurses to work with the practices in relation to the hospital admission avoidance scheme. Patients who were identified as being at high risk for a hospital admission were managed and supported to reduce their risk of an unnecessary admission.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of accident and emergency department (A&E) attendances. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Data showed immunisation uptake rates were at or above average for Leeds North

# Summary of findings

Clinical Commissioning Group. Appointments were available outside of school hours and the premises were suitable for children and babies. Staff we spoke with told us children would always be seen on the same day as requested if needed.

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

Good

The practice is rated good for the care of working age people (including those recently retired and students). Although the practice did not have extended hours they would offer appointments at the beginning and end of surgery to accommodate patients who could not attend during normal surgery hours. They also offered telephone consultations at the end of every morning surgery. There was a full range of health promotion and screening which reflected the needs of this population group, for example health checks for those aged 40 to 74. The practice had a number of students who were registered out of term time with the practice, who were offered full access to GP services.

**People whose circumstances may make them vulnerable**

Good

The practice is rated good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including carers and those who had a learning disability. In the past twelve months the practice had carried out annual health checks for all patients who had a learning disability. Vulnerable people were advised how to access various support groups and voluntary organisations. The practice regularly worked with multidisciplinary teams in the case management of this population group.

The practice operated a priority system for those patients who had extremely complex needs, to ensure they were seen on the same day as requested.

Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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)**

Good

The practice is rated good for the care of people experiencing poor mental health, including people with dementia. The clinical staff actively screened patients for dementia and maintained a list of those diagnosed. Eighty nine percent of patients who had a

diagnosis of dementia had received a face to face review of their care needs. This was higher than the locality average of 84%. Annual health reviews, longer appointments and home visits were offered as needed for all patients within this population group.

The practice worked with other multidisciplinary teams in the case management of people in this population group. They informed patients how to access various support groups and voluntary organisations. For example, signposting patients and carers to the Alzheimer's Society.

# Summary of findings

## What people who use the service say

We received 27 completed CQC comments cards where patients shared their views and experiences of the service. All of the comments were very positive of the practice, the staff and the care they received. Patients said they felt listened to, were treated with respect and had received 'excellent' care and treatment and many thought the practice was 'first class'.

We spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and their comments reflected those on the CQC comment cards. They, again, cited the practice as being 'first class' and told us they had 'no problem' getting an appointment. Patients told us getting their repeat prescriptions was easy and they could obtain them either via the local chemist or from the dispensaries at both practice locations, if they lived more than a mile away. They said they had regular reviews of their medication and the clinicians explained the treatments and choices that were available.

The comments and views of patients aligned with the satisfaction rates from the NHS GP patient survey (July 2015). For example, out of 131 responses:

- 93% said the last GP they saw/spoke with was good at listening to them (CCG 91%)
- 92% said the last GP they saw/spoke with was good at treating them with care and concern (CCG 87%)
- 88% said the last GP they saw/spoke with was good at explaining tests and treatments (CCG 87%)
- 91% said the last GP they saw/spoke with was good at involving them in decisions about their care (CCG 84%)

These were all above average in comparison to the average for local Clinical Commissioning Group practices.

## Areas for improvement

**Action the service SHOULD take to improve**

- The practice should ensure all clinical and non-clinical staff are involved in practice meetings and clinical meetings to support learning, integration and a cohesive approach to service delivery and patient care.
- Review the process for the dispensary accepting medicines ordered from suppliers to ensure the medicines they received were in date and thereby effective.

## Outstanding practice

- The practice had purchased a slit lamp (specialised equipment used to microscopically examine the eye for any abnormalities). This enabled one of the GPs, who was trained in ophthalmology (specialism in eye problems), to undertake eye screening on appropriate patients. This had reduced the need for referral of these patients to hospital.
- The practice had purchased a dermatoscope (specialised equipment used to examine skin lesions more closely). This had been used in early detection of malignant and benign skin lesions It had also reduced unnecessary hospital referrals and skin surgery.

# Collingham Church View Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor and a practice manager specialist advisor. There was also the CQC's National Advisor for Elderly Care in attendance.

## Background to Collingham Church View Surgery

Collingham Church View Surgery is located in the small village of Collingham, which is two miles south of Wetherby and seven miles north of Leeds. There is a branch surgery at Thorner. They provide a range of services to a practice population of 9056 patients; the majority of whom are of white British origin. The practice has a higher proportion of patients aged over 50 years, compared with other practices in the locality.

Collingham Church View Surgery is part of Leeds North Clinical Commissioning Group (CCG) and has a General Medical Services (GMS) contract with NHS England.

The practice has five GP partners (three female, two male) and two salaried GPs (one male, one female). They are supported by three female practice nurses, two health care assistants and a phlebotomist. The management team consists of a recently recruited practice business manager, an assistant practice manager, three secretaries and ten administration/reception staff.

The practice opening times at Collingham are Monday to Friday 8am to 6.30pm, closing for an hour between 1pm and 2pm each day. The Thorner branch is open 8.30am to 12.30 pm Monday to Friday and 3.30pm to 6.15pm Thursdays only. The surgeries are closed one afternoon a month for staff training purposes. When the surgery is closed out-of-hours provision is provided by West Yorkshire Urgent Care Services.

There is a dispensary at both locations which is staffed by a dispensing manager and a team of seven dispensing staff. Medicines are dispensed to patients who live more than a mile from their nearest chemist.

Patients can access the appointment system in person at reception, by telephone or online via the practice website. There are pre-bookable appointments available up to three months in advance. The practice also offers bookable appointments on the day, same day urgent appointments and home visits when needed. The practice offer a range of specialist clinics/services and these include family planning, baby clinic and child health, minor surgery and long term disease management such as diabetes.

There is disabled access to the building and automatic doors to facilitate access for patients in wheelchairs. There is a lower counter in reception where patients can speak more easily to a member of reception. All consulting rooms are on the ground floor.

## 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

# Detailed findings

part of our regulatory functions. This inspection was planned to check whether the registered 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 or data throughout this report, for example any reference to the Quality and Outcomes Framework or NHS England GP patient survey, this relates to the most recent information available to CQC at that time.

## How we carried out this inspection

Before visiting we reviewed information we hold about the practice and asked other organisations and key stakeholders, such as Leeds North Clinical Commissioning Group, to share what they knew about the practice. We asked the practice to provide a range of policies, procedures and other relevant information before the inspection. We also reviewed the latest available NHS England GP patient survey data for the practice.

We carried out an announced inspection on the 23 July 2015 and visited both practice locations. These are Church View Surgery School Lane, Collingham LS22 5BQ and Thorner Surgery, Main Street, Thorner LS14 3DX. Both sites have a dispensary.

During the inspection we spoke with three GPs, the practice manager, the dispensing manager, a receptionist, a practice nurse and a health care assistant. We also spoke with seven patients on the day of the inspection; who were a mix of gender, race and age. We observed how staff responded to and treated patients whilst they were at the practice.

We reviewed 27 CQC comment cards where patients had shared their views and experiences of the practice.

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

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

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

- Older people
- People with long term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people who have dementia)

Good

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. These included investigating reported incidents, checking national patient safety alerts and sharing comments and complaints received from patients. We reviewed safety records and incident reports.

Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. Staff told us there was an open and transparent culture at the practice and they were encouraged to report adverse events and incidents. Documented evidence confirmed incidents were appropriately reported. Records were available which showed the practice had managed these consistently and could demonstrate a safe track record over the long term.

**Learning and improvement from safety incidents**

There were systems in place for how the practice managed safety alerts, significant events, incidents and accidents. Safety alerts were disseminated to staff by the practice manager or the assistant practice manager in their absence. These were then forwarded to all the clinical and non-clinical staff, as appropriate. All medicine alerts were also forwarded to the dispensing manager for evaluation and distribution. These would be discussed with the GPs if there were any relevant issues.

Both the GP and practice manager explained to us the reporting system the practice used to record, manage and monitor all clinical and non-clinical incidents. We were informed incidents were discussed at the weekly practice meetings held with the GP partners and practice manager. We saw minutes which confirmed this. We reviewed a summary of incidents which had been reported over the past twelve months and saw they had been completed in a comprehensive and timely manner. We were given several examples, such as what happened when the practice found a patient was inappropriately self-medicating. There was evidence the practice had identified actions and learning from these and had shared them with the staff.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to children, young people and adults whose circumstances may make them vulnerable. We looked at training records which showed all the staff had received relevant role specific training on safeguarding. Staff we spoke with were aware of their responsibilities and knew how to share information, record safeguarding concerns and how to contact the relevant agencies in both working hours and out of hours. Safeguarding policies, procedures and the contact details of relevant agencies were available and easily accessible for all staff.

The practice had appointed a designated GP lead for both safeguarding children and vulnerable adults and there was also a deputy GP lead. The leads had received training suitable for their role. All staff we spoke with were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern. Both clinical and non-clinical staff gave us several examples where they had identified patients about whom they had safeguarding concerns. They could clearly tell us the circumstances, how they had reported it and any actions that had been undertaken. Examples given involved a child at risk and an issue of domestic abuse.

There was a system in place to highlight vulnerable patients on the practice's electronic record. The practice held regular multidisciplinary meetings with other professionals, such as the health visitor, district nurses and palliative care nurses, to discuss concerns and share information about children and any vulnerable patients who were registered at the practice. We were shown how these patients were flagged on the computer system to alert staff and how clinicians identified whether there were any children who may have a child protection plan in place. (A child protection plan is a plan drawn up by the local authority. It sets out how the child can be kept safe, how things can be made better for the family and what support they will need.) The GP lead for safeguarding told us how they had recently identified a need for specific meetings with the health visitor to discuss complex safeguarding cases. These meetings were to be held on a three monthly basis.

There was a chaperone policy in place which was due for review in June 2016. Notices were displayed in the reception area which highlighted the availability of a chaperone if required. Nursing and reception staff acted in the capacity of chaperone and received appropriate checks through the Disclosure and Barring Services (DBS). They had undertaken chaperone training and could explain what

their roles and responsibilities were. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) We were told patients' records were coded as to whether a chaperone was present.

**Medicines management**

We looked at the areas where medicines were stored at both the Collingham and Thorner practice locations. All were stored securely.

Vaccines were stored in locked refrigerators and a policy was in place for ensuring vaccines were kept at the required temperatures. There were processes to check refrigerator temperatures on a daily basis and that vaccines were within their expiry date. We saw evidence of records being kept to reflect these processes. We checked a sample of vaccines and observed they were all within their expiry dates. The practice informed us expired and unwanted medicines were disposed of in line with waste regulations.

We checked a sample of the GPs bags which contained various clinical equipment and medicines. It was observed that one vial of medicine was out of date this was removed from the bag and destroyed immediately by the clinician. All other medicines were in date.

The nursing staff used patient group directions and patient specific directions to administer vaccines and other medicines. These had been produced in line with legal requirements and national guidance. We saw evidence relevant staff had received training to administer vaccines.

Requests for repeat prescriptions were taken in person at the reception desk, by post or over the internet. Administration/reception staff told us the checks undertaken prior to dispensing a prescription. For example, name, address and date of birth of the patient. All prescriptions were reviewed and signed by a GP before they were issued. There was a process in place for checking all medication reviews had been undertaken before issuing a repeat prescription. Blank prescription forms were handled in accordance with national guidance and were tracked through the practice and kept securely at all times.

There was a dispensary at both the Collingham and Thorner surgeries. We spent time in both dispensaries observing practises, talking to staff and looking at records. We noted the dispensaries were well organised and operated with adequate staffing levels. We spoke with the dispensing manager who comprehensively described the system for dealing with prescriptions, dispensing of medicines and stock control. We were shown both the electronic and manual systems used for cross-checking stock.

We checked a random sample of stored medicines and found five items of the same medicine were out of date at one of the dispensaries. We were informed these had only been delivered the previous day by the supplier and none had been issued to patients. We discussed the process used when the dispensary received new medicines and found it did not include checking expiry dates. (This would be done before issuing to the patient via a prescription.) We were assured the process for receiving medicines would be reviewed to include checking expiry dates. The incident was also reported to the practice manager by the dispensing manager and processed in line with incident reporting. We saw evidence the practice recorded and monitored any dispensing errors or near misses and audits of stock control, prescribing and dispensing arrangements were carried out regularly. We were assured there was a culture of learning from medicine related incidents.

The arrangements to control access to the dispensary and the controlled drug cupboard were robust. All keys were held securely throughout the day. A designated person was the key holder for the shift and all staff were aware of who that was. The controlled drug cupboard was kept locked and we saw the records that related to those drugs were all in order.

All dispensing staff had received relevant training, had regular updates and had access to a clinician as needed. There were arrangements in place for the security of the dispensary so that it was only accessible to authorised staff. The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary.

**Cleanliness and infection control**

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection prevention and control (IPC) who had received appropriate training. There was an

Good

# Are services safe?

IPC policy in place, which had been reviewed in March 2015, and was available for staff to refer. An IPC audit had been completed in October 2014, actions had been identified and completed.

Personal protective equipment including disposable gloves and aprons were available for staff to use. Hand washing sinks with hand soap, antibacterial gel and hand towel dispensers were available in treatment rooms. Sharps bins were appropriately located and labelled. The practice had access to spillage kits and staff told us how they would respond to blood and body fluid spillages, in accordance with current guidance.

The practice had a risk assessment for the management of legionella (a bacterium which can contaminate water systems in buildings). The last assessment had been completed in March 2015; in line with Health and Safety Executive guidance.

**Equipment**

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly. We saw equipment maintenance logs, contracts and other records which confirmed this. A schedule was in place for annual checks of equipment, which included calibration and portable appliance testing. The sample of equipment we inspected had all been tested and was in date.

**Staffing and recruitment**

The practice had a recruitment policy which set out the standards it followed when they recruited clinical and non-clinical staff. There was a structured induction programme available for new starters. We looked at files for the most recently recruited staff and saw evidence appropriate recruitment checks had been undertaken prior to their employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS).

We were informed of the arrangements for how the practice planned and monitored the number and mix of staff required to meet the needs of patients. There was an arrangement in place for members of staff to cover each other's annual leave and sickness. The GPs had a buddy system to ensure all letters and test results were dealt with in a timely manner. There was a delegated duty doctor available for each shift. We were told there were usually enough staff to maintain the smooth running of the practice and always enough staff on duty to keep patients safe.

GP locums were used on an ad hoc basis, mainly to cover annual leave. We were told the practice tried to use the same locums to sustain patient continuity of care. At the time of the inspection there was no current locum induction pack available; we were assured the practice would put one in place.

**Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, equipment and dealing with emergencies. The practice had a health and safety policy in place and information was available for staff.

Staff told us they would inform the practice manager if they identified any issues or risks. These were then dealt with in a timely manner and were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage risk. We were told any identified risks were discussed at GP partners' meetings and cascaded to staff.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available, including access to oxygen and an automated external defibrillator (this is used to attempt to restart a person's heart in an emergency). Members of staff we spoke with knew the location of this equipment and how to use it. We saw records which confirmed it was checked on a monthly basis.

Emergency medicines were available in a secure area of the practice. Staff checked the medicines on a monthly basis and we saw records which corroborated this. We checked the medicines at the time of inspection and found them all to be in date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Good

# Are services safe?

the practice. Risks were identified and included power failure, adverse weather and access to the building. The document contained relevant contact details for staff to refer. For example, water, gas and electricity suppliers. A copy was available electronically and the GPs and practice manager all had copies at their homes.

An up to date fire risk assessment had been carried out. Fire alarms were tested on a weekly basis; the last one being on the 17 July 2015. We saw evidence fire-fighting equipment was checked regularly. There was an evacuation policy which identified named fire marshals and had a review date of July 2016. All staff were up to date with fire safety training. Ambi-chairs were available in the reception area which could be used for those people who had mobility difficulties

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The clinical staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told the GPs held regular practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs and nursing staff they completed thorough assessments of patients' needs in line with NICE guidance and these were reviewed when appropriate.

There were systems in place to identify and monitor the health of vulnerable groups of patients. We were told patients who had learning disabilities were given longer appointments, annual reviews were undertaken and consent was documented in the patient's electronic record. Staff were able to demonstrate how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective.

Collingham Church View Surgery, in conjunction with four local practices, had recently co-funded the employment of three additional nurses to work with the practices in relation to the hospital admission avoidance scheme. These nurses supported the patients who had been identified as being most at risk of an unplanned hospital admission. These patients were reviewed regularly to ensure their needs were being met to assist in reducing the need for them to go into hospital. They were also discussed at multidisciplinary meetings with other health professionals such as district nurses, to ensure a cohesive and consistent package of care and support was provided for those patients. Because the work being delivered by these nurses was in its infancy at the time of our inspection there wasn't any data available to demonstrate any reductions in unplanned hospital admissions.

The practice kept up to date disease registers for patients with long term conditions, such as asthma and diabetes. All these patients had a named GP and a structured annual review to check their health and medication needs were met. These reviews were offered around the birthday of the patient, which helped to remind a patient when they were due a review. Clinicians used the Year of Care approach to provide personalised care planning for patients who had a long term condition. This approach supports patients to self-manage their own care, in conjunction with health professionals, and the actions they want to take to improve their health and well-being.

We were informed GPs had a lead in specialist clinical areas such as diabetes, dermatology and ophthalmology (specialism in eye problems). The practice had purchased a slit lamp, which is specialised equipment used to microscopically examine the eye for any abnormalities or problems such as glaucoma and a detached retina. In addition, the practice had also purchased a dermatoscope, which is used to examine skin lesions more closely. This had been used in early detection of malignant and benign skin lesions. By using these pieces of specialist equipment they have supported patient care to be delivered locally by clinicians, reducing the need of unnecessary referral of patients to hospital. At the time of our inspection the practice could not provide data to identify what percentage of reductions in referrals they had achieved.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It had a register of patients who required palliative care. Regular meetings to discuss these patients' care needs were held with health professionals, such as members of the district nursing team and palliative care nurses.

Interviews with staff showed the culture of the practice was that patients were cared for and treated based on need. The practice took into account a patient's age, gender race and culture as appropriate and avoided any discriminatory practises.

**Management, monitoring and improving outcomes for people**

Staff across the practice had key roles in how they monitored and improved outcomes for patients. These roles included data input, scheduled clinical reviews, how they managed child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service.

Information collected for the quality and outcomes framework (QOF) and performance against national screening programmes was used to monitor outcomes for

Good

# Are services effective?

## (for example, treatment is effective)

patients. (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.) In 2014 the practice was above average for many of the QOF domains, in comparison to other practices within the local Clinical Commissioning Group (CCG); specifically in the management of epilepsy, diabetes, learning disabilities and mental health. The practice discussed QOF in their meetings and we saw evidence to support this.

Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had an effective system in place for how they completed clinical audit cycles. We saw several audits had been undertaken in the past twelve months. For example, medication returns, management of heart disease and the use of anti-psychotics in dementia. After each audit, actions had been identified and changes to treatment or care had been made as appropriate. Repeat audits had been undertaken within 12 months to ensure good practice was maintained and the changes had been effective.

**Effective staffing**

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with attending mandatory training courses, such as annual basic life support and safeguarding adults and children. We saw staff had received training appropriate to their role and the practice manager kept a training matrix to enable them to monitor when updates were due. The practice also took time out to attend specific training and learning sessions, known as TARGET events, which were supported by the local CCG. All staff had annual appraisals and staff we spoke with confirmed these had taken place.

All GPs were up to date with their continuing professional development requirements and all had either 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.) We noted there was a good skill mix amongst the GPs with a number having special interests in diabetes, dermatology, ophthalmology and safeguarding.

The practice nurses were registered with the Nursing and Midwifery Council. To maintain registration they had to complete regular training and keep their skills up to date. The nurses we spoke with confirmed their professional development was up to date and they had received training necessary for their role.

We were told all new staff underwent a period of induction. The induction programme covered a range of areas, including being introduced to other members of staff, health and safety information, fire safety and confidentiality.

All the staff we spoke with told us they felt supported in their role and confident they could raise any issues or concerns with the GPs or practice manager.

**Working with colleagues and other services**

The practice worked with other service providers to meet patients' needs and manage those who had complex needs. It received letters, discharge summaries, blood test and X-ray results both electronically and by post from other services, such as the local hospital and out-of-hours services. There were systems in place for receiving, passing on, reading and acting on any issues arising from communications with other care providers. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary (MDT) meetings to monitor patients at risk, review patients' needs and manage complex cases. We saw minutes which identified other health professionals who attended these meetings, for example health visitors, district nursing staff and palliative care nurses. The staff told us they liaised closely with the health and social care professionals to ensure the needs of their patients were promptly addressed, for example child and adolescent mental health services (CAMHS). They also worked with voluntary services, such as Wetherby in Support of the Elderly (WISE) and the Home from Hospital Service operated by the Red Cross, to support older people to live independently in their own homes.

We were informed of the meetings one of the GPs has on a weekly basis with the midwife to discuss any 'problem' pregnancies. They are also commencing a health visitor and safeguarding lead meeting to discuss specific safeguarding issues in complex cases; in addition to the MDT meetings which take place.

Good

# Are services effective?

## (for example, treatment is effective)

The practice met with other GP practices in the area to share information, best practice and look at developing services to meet the needs of the practice population. For example, they had recently co-funded with other practices the employment of two nurses specialising in dementia. The nurses operated from a 'one stop' clinic based in Wetherby, supported by a consultant psychiatrist, to provide care, treatment and support to patients who had a diagnosis of dementia. They also provided support for carers of people who had dementia. Because the service was in its infancy there wasn't any current data to demonstrate the effectiveness of the service.

**Information sharing**

The practice used electronic systems to communicate with other providers. There was a shared system with the local GP out-of-hours (OOH) provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients who had complex needs with the ambulance and out-of-hours services. For example, those who were on an end of life care pathway and/or had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. This was to ensure continuity of care and avoid any unnecessary distress to patients.

Staff used an electronic patient record to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from the hospital, to be saved in the system for future reference.

Electronic systems were in place for making referrals which, in consultation with the patients, could be done through the Choose and Book system. (The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.)

The practice worked collaboratively with other agencies and community health professionals. They regularly shared information to ensure timely communication of changes in care and treatment. This included liaison with midwives, health visitors, district nurses and mental health services.

**Consent to care and treatment**

Clinicians had received training on the Mental Capacity Act 2005 and understood the key parts of the legislation in relation to the Act. The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Staff could demonstrate instances where they had used the MCA and when best interest decisions needed to be made.

Clinical staff demonstrated an understanding of legal requirements when treating children under the age of 16, particularly in relation to the Gillick competency test. This is used to help assess whether a child under 16 has the maturity and understanding to make their own decisions and to understand the implications of those decisions.

The clinicians we spoke with described the process to ensure consent was obtained from patients when necessary. For example, when patients required minor surgery we were informed verbal consent was recorded in their records.

**Health promotion and prevention**

The practice supported patients to manage their health and well-being and offered NHS health checks to all its patients over the age of 40. It promoted the national breast, bowel and cervical cytology screening programmes. Data showed the practice had achieved a 92% uptake rate for cervical screening compared to the CCG average of 82%. They had also achieved a higher than CCG average uptake of patients who accessed bowel screening, at 69% compared to 60%. The practice offered a full range of childhood immunisations and had achieved a 93% uptake for children; which was comparable to the local CCG average. Seasonal flu vaccinations and travel vaccinations were offered in line with current national guidance. The practice was also registered as a Yellow Fever Centre where patients from other areas could access vaccination. The practice had a protocol in place and we were shown the template used to record patient and vaccination details.

The practice identified patients who needed ongoing support with their health. They kept up to date registers for patients who had a long term condition, such as diabetes or asthma, which were used to arrange annual health reviews. Registers and annual health checks were also available for vulnerable patients, such as those with a learning disability, and the over 75s.

Healthy lifestyle information was available to patients via leaflets and posters in the waiting room and also accessible through the practice website. This included smoking

Good

# Are services effective?

## (for example, treatment is effective)

cessation, weight management and travel health. Patients were signposted to other services as the need arose, for example voluntary support groups. Chlamydia self-testing kits were available from reception and the clinicians.

The practice was in the process of locating a 'surgerypod' within the reception area. This equipment enables patients to self-assess their health, including having a blood pressure check, support weight management and screen for anxiety or depression. The data is then sent electronically to the patient's record and can flag any areas for concern, which then triggers a recall for an appointment with a clinician.

Good

# 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 NHS England GP patient survey (July 2015), where from a sample of 258 questionnaires, 131 (51%) responses were received. Data from this survey showed the practice to be comparable to the local Clinical Commissioning Group for the following satisfaction scores:

- 92% said the last nurse they saw/spoke with was good at listening to them (CCG 91%)
- 93% said the last GP they saw/spoke with was good at listening to them (CCG 91%)
- 99% said they had confidence or trust in the last nurse they saw/spoke with (CCG 98%)
- 96% said they had confidence or trust in the last GP they saw/spoke with (CCG 96%)

We received 27 completed CQC comments cards where patients shared their views and experiences of the service. All of the comments were very positive of the practice, the staff and the care they received. Patients said they felt listened to, were treated with respect and had received 'excellent' care and treatment and many thought the practice was 'first class'.

We spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and their comments reflected those on the CQC comment cards. They, again, cited the practice as being 'first class' and told us they had 'no problem' getting an appointment.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms to ensure patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation/treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We observed reception staff were courteous, spoke respectfully to patients and were careful to follow the practice's confidentiality policy. We observed conversations between patients and staff in the reception were not easily overheard. We were told there was a room available for patients who wished to speak privately to a member of reception staff.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour, or where a patient's privacy and dignity was not being respected they would raise these concerns with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

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

The NHS England GP patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 91% of respondents said the GP involved them in care decisions and 90% felt they had enough time to make an informed decision about the choice of treatment they wished to receive. These were both higher than the local CCG average; 84% and 88% respectively.

Patients we spoke with on the day or our inspection told us health conditions were discussed with them, treatments were explained 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.

Patient feedback on the comment forms we received were also positive and aligned with these views.

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

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated them at or above average, compared to the local CCG. For example, 92% of respondents said the last GP they saw or spoke with was good at treating them with care and concern (CCG 87%).

The patients we spoke with on the day or our inspection and the comment cards we received were also consistent with the survey information. They told us staff were kind, caring and considerate and provided support when needed. We were informed the GPs contacted patients who had experienced a bereavement to offer them support and signpost to other services if necessary.

Good

# Are services caring?

Notices in the patient waiting area and on the practice website provided information on how to access a number of support groups and organisations. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice held a register of carers and the patient record system alerted a clinician if a patient was also a carer.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The NHS England Area Team and Leeds North Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements.

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 in the way services were delivered. For example, same day service clinics and extended hours appointments.

The practice provided a service for all age and population groups. Registers were maintained of patients who had a learning disability, a long term condition or required palliative care. These patients were discussed at the weekly clinical and monthly multidisciplinary meetings to ensure practitioners responded appropriately to the care needs of those patients.

**Tackling inequity and promoting equality**

The practice had recognised the needs of patients in the planning of its services. For example, longer appointment times were available for patients who were vulnerable, had complex needs or required interpreting services. Hearing loops were available in the reception and consulting rooms for those patients who had a hearing impairment.

There was disabled access to the building and automatic doors to facilitate access for patients in wheelchairs. There was a lowered counter in reception where patients could speak more easily to a member of reception. All consulting rooms were on the ground floor. Accessible toilet facilities were available for all patients who attended the practice.

There were male and female GPs in the practice, giving patients a choice as to whom they may wish to see. There was access to translation services should the need arise. There was a private room available for patients who may be anxious or distressed whilst waiting in the reception area, or who required privacy. For example, a breastfeeding mother.

**Access to the service**

The practice was open from 8am to 6.30pm Monday to Friday. Information regarding the practice opening times, how to book appointments and out-of-hours care provision was displayed in the reception area, the practice leaflet and on the website.

Patients could book appointments by telephone, online or in person at the reception. Appointments were pre-bookable up to three months in advance and some were available on the day of request. Home visits were offered for patients who found it difficult to access the surgery.

We saw the next routine bookable appointment was for the next day following the inspection. We were informed patients who required to be seen urgently would be accommodated on the same day. Pre-bookable appointments could be made up to three months in advance.

We reviewed the most recent data available for the practice on patient satisfaction regarding access to the practice and appointments. This included information from the NHS England GP patient survey published in July 2015. The practice was above the local CCG average. For example, out of 131 responses:

- 94% said they found it easy to get through to the surgery by telephone (CCG 79%)
- 74% usually get to see/speak with their preferred GP (CCG 60%)
- 86% usually waited 15 minutes or less after their appointment time to be seen (CCG 72%)
- 90% described their experience of making an appointment as good (CCG 77%)

Patients we spoke with on the day or our inspection, and comments on the CQC cards aligned with the survey results.

We saw evidence the practice periodically reviewed the appointment system and availability of face-to-face and telephone appointments. For example, the practice had increased the number of bookable online appointments as a result of demand.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

in line with recognised guidance and contractual obligations for GPs in England and had a review date of March 2016. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system. The patients we spoke with told us they would speak to a member of staff, the practice manager or write to the practice if they wished to make a complaint. None of the patients we spoke with had made a complaint about the practice.

We looked at complaints the practice had received over the past twelve months. These had all been dealt with in line with the practice policy, identifying action taken and any lessons learned. We were informed shared learning from these was disseminated to staff.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

Staff we spoke with told us the vision and values of the practice had quality service delivery, patient care and safety as its priority. They aimed to maintain provision of a good service which provided excellent care and promote positive outcomes for its patients. They told us they delivered a professional service in a friendly, caring and respectful way. This was supported by comments patients made.

Staff we spoke with knew and understood the visions and values and what their responsibilities were in relation to these. There had been changes within the practice as some of the GPs and a previous practice manager had retired. The majority of staff told us they felt it had been a smooth transition and had been well informed.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were accessible to staff. We looked at several of these and saw they had all been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a clinical lead for infection prevention and control and a GP lead for safeguarding. The staff we spoke with were all clear about their own roles and responsibilities.

The GPs, practice business manager and assistant practice manager took active roles for overseeing the systems in place to monitor the quality of the service were being used consistently and effectively. These included using the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at practice meetings.

The practice had an ongoing programme of clinical audits which were used to monitor quality and to identify where any action should be taken. Evidence from other data sources, including incidents and complaints, was used to identify where improvements could be made. Additionally, there were processes in place to review patient satisfaction and action taken in response to feedback from patients or staff. The practice regularly submitted governance and performance data to Leeds North Clinical Commissioning Group.

The practice identified, recorded and managed risks. Risk assessments had been undertaken, for example fire, infection prevention and control and legionella. The practice monitored risks and discussed any issues at the practice meetings.

**Leadership, openness and transparency**

The GP partners and managers were visible in the practice and staff told us there was an open culture and all members of the management team were approachable, supportive and appreciative of their work. Systems were in place to encourage staff to raise concerns and a 'no blame' culture was evident at the practice.

The practice manager and GP partners had a weekly practice meeting. There appeared to be an exclusive approach to meetings, as we were informed the salaried and retainer GPs were not included in the practice meetings. The administrative/reception staff met regularly with the practice managers and the nursing staff had their own meetings. There was little evidence of a whole practice approach to meetings, with the exception of staff attending the quarterly training events. We were informed this had been identified as an issue and plans were being developed to have more staff inclusive meetings.

**Seeking and acting on feedback from patients, the public and staff**

The practice encouraged and valued feedback from patients and staff. They had gathered feedback from patients through patient surveys, the NHS friend and family test, complaints and compliments. It had an established patient participation (PPG) that met regularly. (A PPG is a group of patients registered with the practice who work with the practice to improve services and the quality of care.) The group had identified various issues for the practice to improve and we saw evidence where actions had been taken. For example, a hand rail was being fitted on the pathway to the surgery entrance to provide support for patients who may have mobility difficulties.

# Are services well-led?

Good

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

The practice had also gathered feedback from staff through meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

**Management lead through learning and improvement**

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. They told us annual appraisals took place, which identified any training and development needs. This was evidenced in the staff files we looked at. Staff told us the practice was very supportive of training and they attended regular training sessions where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and training events to ensure the practice improved outcomes for patients.