# The Petergate Surgery

## Quality Report

Tower Court Health Centre
Oakdale Road
Clifton Moor
York
YO30 4RZ
Tel: 01904 479111
Website: http://www.petergatesurgery.co.uk/index.aspx

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

## Ratings

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

# Summary of findings

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## Overall summary

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

We carried out an announced comprehensive inspection at The Petergate Surgery on 16 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services that meet the needs of the population it served.

Our key findings were as follows:

- Patients who use the service were kept safe and protected from avoidable harm. The building was well maintained and clean.
- All the patients we spoke with were positive about the care and treatment they received. The CQC comment cards and results of patient surveys showed that patients were consistently pleased with the service they received.
- There was good collaborative working between the practice and other health and social care agencies that ensured patients received the best outcomes. Clinical decisions followed best practice guidelines.
- The practice met with the local Clinical Commissioning Group (CCG) to discuss service performance and improvement issues.
- There were good governance and risk management measures in place. The leadership team were visible and staff we spoke with said they found them very approachable.

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

Importantly the provider should:

- Ensure a process is in place to confirm the vaccines remain at required temperature when being transported from the main surgery to the branch surgery.
- Review the practice meetings to ensure all staff groups are represented and information is communicated effectively.
- Implement a planned audit programme to ensure all practice staff are included in the process.

# Summary of findings

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to staff to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Data showed the practice was not an outlier for any clinical indicators. Care and treatment was being considered in line with current guidelines and legislation. This included assessing capacity and promoting good health. Patient's needs were consistently met and referrals to other services were made in a timely manner. Staff worked with multidisciplinary teams. The practice undertook clinical audit and monitored the performance of staff. Staff had received training appropriate to their roles.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well for several aspects of care. Feedback from patients about their care and treatment was positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Following feedback from patients the practice had employed two new doctors to improve the availability of appointments. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and the practice responded to complaints and comments appropriately.

# Summary of findings

**Are services well-led?**

Good

The practice is rated as good for being well-led. The leadership team was visible and it had a clear vision and purpose. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Governance arrangements were in place and there were systems for identifying and managing risks. Staff were committed to maintaining and improving standards of care. Key staff were identified as leads for different areas in the practice and they encouraged good working relationships amongst the practice staff. Staff were well supported by the GPs and practice manager.

# 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 as good for the care of older people. The practice was knowledgeable about the number and health needs of older patients using the service and actively reviewed the care and treatment needs of these patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Patients over the age of 75 had a named GP. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice had agreed to deliver the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme Enhanced Services". This was a strategy where the practice would liaise with local health and social care commissioners to work together for people with complex health needs. The nurses would work specifically with patients over the age of 75 to develop individualised care plans.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. Staff had a good understanding of the care and treatment needs of these patients and nursing staff had lead roles in chronic disease management. The practice closely monitored the needs of this patient group. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. There was a recall programme in place to make sure no patient missed their regular reviews for conditions, such as diabetes, respiratory and cardiovascular problems. We heard from patients that staff invited them for routine checks and reviews. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Staff were skilled and regularly updated in specialist areas which helped them ensure best practice guidance was being followed.

**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 A&E attendances. The practice offered comprehensive vaccination

programmes which were managed effectively. Immunisation rates were relatively high for all standard childhood immunisations. The practice monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns. The practice did 'Booster Vaccination Clinics' during school holidays for patients aged 14 to 18 years so young people who had not received required vaccinations during term time could access them whilst on holiday.

Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were responsive to parents' concerns and ensured children who were unwell could be seen quickly by the GP or nurse.

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

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this population group 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 provided a range of options for patients to consult with the GP and nurse, including on-line booking. Useful information was available in the practice and on the website as well as a full range of health promotion and screening that reflected the needs for this age group.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Where required the practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice offered these patients longer appointments. We found that all of the staff had a very good understanding of what services were available within their catchment area, such as supported living services, care homes and patients with carer responsibilities.

Staff knew how to recognise signs of abuse in vulnerable adults and children. 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. They had access to the practices' policy and procedures and discussed vulnerable patients at the practice meetings.

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

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice

# Summary of findings

maintained a register of patients who experienced mental health problems including dementia. The register supported clinical staff to offer patients an annual appointment for a health check and a medicines review and 88.2% of patients with dementia had received a face to face review during 2013/2014.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice offered access to other services and information was available for patients on counselling services and support groups.

# Summary of findings

## What people who use the service say

As part of this inspection we had provided CQC comment cards for patients who attended the practice to complete. We received responses from 11 patients which were positive about the care and treatment they received from the practice. Patients said staff were polite and helpful and always treated them with dignity and respect. Patients described the service as excellent and praised the GPs and nurses for their understanding and effective treatment.

We spoke with 16 patients during the inspection and they also confirmed that they had received good care and attention and they felt that all the staff treated them with dignity and respect. Feedback from patients showed that staff were good at listening and explaining things to them. They felt the doctors and nurses were knowledgeable about their treatment needs. However the patients told us they had to wait up to three weeks for a routine appointment.

We looked at the results of the national GP survey for 2014 where 113 patients had responded. Results showed that patients were generally positive about the service they received however again there were some areas relating to the appointment system where the practice performed below the weighted CCG (regional) average. For example:

- 74% of respondents would recommend this surgery to someone new to the area - CCG local average: 84%
- 62% of patients said it was easy to get through to the practice on the phone - CCG local average: 81%
- 58% of respondents describe their experience of making an appointment as good - Local (CCG) average: 78%
- 62% of respondents find it easy to get through to this surgery by phone - Local (CCG) average: 81%
- 81% of respondents describe their overall experience of this surgery as good – CCG local average: 84**%**
- 90% of respondents said the last GP they saw or spoke to was good at giving them enough time – CCG local average: 89%
- 84% of respondents find receptionists at this surgery helpful – CCG average: 90%

We looked at the results of the Practice's survey for 2014 which 140 patients had completed and saw they were also positive about the care patients received but identified issues with the appointment system.

These results were consistent with our findings on the day of the inspection.

We found that the practice valued the views of patients and saw that following feedback from surveys and from patients attending the practice; changes were made to improve the service. The practice had taken action to address the issues with the appointment system.

## Areas for improvement

**Action the service SHOULD take to improve**

Ensure a process is in place to confirm the vaccines remain at required temperature when being transported from the main surgery to the branch surgery.

Review the practice meetings to ensure all staff groups are represented and information is communicated effectively.

Implement a planned audit programme to ensure all practice staff are included in the process.

# The Petergate Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Inspector and the team included a GP Specialist Advisor, a Practice Manager Specialist Advisor and an Expert by Experience.

## Background to The Petergate Surgery

The Petergate Surgery is situated in York and provides primary medical care services, which includes access to GPs, minor surgery, family planning, ante and post natal care to patients living in the city of York. The practice also has a branch surgery in the village of Skelton where regulated activities are also provided, we did not visit the branch surgery during the inspection.

The practice provides services to 6361 patients of all ages. There is a slightly higher percentage of the practice population in the under 18 age group than the England average and a lower percentage in the 65 years and over age group than the England average. The overall practice deprivation score is significantly below the England average, the practice is 9.67 and the England average is 23.6.

The practice has three GP partners and two salaried GPs, one male and four female. The practice is a teaching practice for medical students from the Hull and York Medical School. There are two nurse practitioners, one practice nurse and two health care assistants. There is one practice manager and a team of secretarial, reception, administrative and support staff.

The practice provides services to their patients through a General Medical Services contract.

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

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out an announced inspection 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.

## How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

# Detailed findings

- 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 held about the service and asked other organisations to share what they knew about the service. We reviewed policies, procedures and other information the practice provided before and during the inspection. We carried out an announced visit on 16 December 2014.

During our visit we spoke with a range of staff including two GP partners, the specialist nurse practitioner and two health care assistants. We also spoke with the practice manager, secretary and receptionists. We spoke with 16 patients who used the service and observed how staff spoke to, and interacted with patients when they were in the practice and on the telephone. We also reviewed 11 CQC comment cards where patients were able to share their views and experiences of the service.

Good

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example an incident had been reported where the referral for a patient had not been sent to the hospital.

The practice had a record of the incidents that had occurred in the practice which showed the practice had managed these consistently over time. However, an annual review of all the incidents to identify any themes or trends, for example how many medicines related incidents had occurred, would enable the practice to confirm the measures they had taken to prevent any recurrence were continuing to work.

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records of significant events that had occurred during the last 12 months and we were able to review these. The practice discussed incidents at the practice meetings which occurred every week. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the practice meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw evidence of actions taken following incidents. For example the practice had changed their procedure when making referrals to hospitals or other services following an incident when a referral had not been sent. Patients were now asked to contact the practice after a defined period of time if they did not receive an appointment from the service they had been referred to.

National patient safety alerts were disseminated by e mail to practice staff who then took any action required. Where necessary alerts were discussed at the practice meetings to ensure all any action that was needed was considered and agreed. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that staff had received relevant role specific training on safeguarding. 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 and document safeguarding concerns, and how to contact the relevant agencies in working hours and out of normal hours.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary knowledge to enable them to fulfil this role. Staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. The GP explained how they worked with the Health Visiting and Social Services teams when they had safeguarding concerns.

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; for example children subject to child protection plans or patients with dementia.

GPs were appropriately using the required codes on the electronic records system to ensure risks to children and young people who were on looked after or child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and we saw evidence of good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the attention of the GPs, who then worked with other health professionals such as health visitors, midwives and district nurses. We saw minutes of meetings where vulnerable patients were discussed.

Good

# Are services safe?

There was a chaperone policy, and information informing patients that they could ask for a chaperone was visible in the waiting room and in consulting rooms. (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). Nursing staff, health care assistants and administration staff acted as chaperones and understood their responsibilities, including where to stand to be able to observe the examination.

**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. There was a clear procedure for ensuring that medicines were kept at the required temperatures and the action to take in the event of a potential failure.

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.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that the nurse had received appropriate training to administer vaccines. The practice did not keep records to confirm that vaccines were kept cold when transferred from the main surgery to the branch surgery at Skelton.

There was a system in place for the management of high risk medicines, for example Warfarin. This included regular monitoring of patients in line with national guidance and appropriate action being taken based on the results of blood tests to ensure patients received the correct dose of medication.

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 secure at all times.

**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 clean and had no concerns about cleanliness or infection control.

Infection prevention and control (IPC) procedures had been developed which provided staff with guidance and information to assist them in minimising the risk of infection. There was a nominated lead for IPC who was responsible for ensuring good practice was followed. External advice and support was available for practice staff. All staff received induction training about infection control specific to their role and received regular updates.

The practice monitored the standards of cleaning in the practice regularly so any areas for improvement could be identified and actioned. We saw evidence that monitoring had been carried out however there were no action plans to confirm any improvements identified were completed.

Staff told us there was always sufficient personal protective equipment (PPE) available for them to use, including masks, disposable gloves and aprons and staff were able to describe how they would use these to comply with the practice's infection control procedures. For example staff told us they wore disposable gloves when handling specimens such as blood or urine. We saw that hand wash; disposable towels and hand gel dispensers were also readily available for staff. We observed that there was hand gel in the waiting area for patients to use. Staff confirmed they had completed training in infection prevention and control. Sharps bins were appropriately located, labelled, closed and stored after use. There was a contract in place for the removal of all household, clinical and sharps waste and we saw evidence that waste was removed by an approved contractor. Staff told us that equipment used for procedures such as cervical smear tests were disposable. Staff therefore were not required to clean or sterilise any instruments, which reduced the risk of infection for patients. We saw that other equipment used in the practice was clean.

Staff told us how they would respond to needle stick injuries and blood or body fluid spillages and this met with current guidance.

Systems for the management, testing and investigation of legionella (a bacterium that can grow in contaminated

water and can be potentially fatal) were in place. We saw records that confirmed the practice was carrying out regular checks to reduce the risk of infection to staff and patients.

**Equipment**

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all medical equipment was tested and maintained regularly and we saw records that confirmed this. For example weighing scales and BP machines had all been checked within the last 12 months. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

**Staffing and recruitment**

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staff groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave or sickness.

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. Feedback from patients we spoke with and on the CQC comment cards and surveys confirmed they could get a same day appointment when they needed to.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

**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 and the environment. The practice had a health and safety policy which identified who the health and safety lead was and how health and safety would be managed and risks controlled.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff told us about referrals they had made for patients with respiratory problems whose health had deteriorated suddenly and how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

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

The practice had arrangements in place to manage emergencies. Emergency equipment was available including an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and the practice was awaiting the delivery of an oxygen cylinder. Emergency medicines were available; these included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check the emergency equipment was working and that emergency medicines were within their expiry date and suitable for use. Records confirmed that equipment was checked regularly to ensure it was working and that medicines had not expired. All the medicines we checked were in date and fit for use.

Records showed that all staff had received training in basic life support and the staff we spoke with were able to describe what action they would take in the event of a medical emergency situation. They all knew the location of the emergency airway equipment, de-fibrillator and medicines.

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, adverse weather, unplanned staff sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff had received fire training and regular fire drills had been carried out.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance was readily accessible in the clinical and consulting rooms. We discussed with the practice manager, GP and nurses how NICE guidance was received into the practice. They told us that this was downloaded from the website and disseminated to staff. We saw minutes of practice meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and the nurse that staff completed thorough assessments of patients' needs in line with national and local guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, children's and women's health and the elderly. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The nurses told us they continually reviewed and discussed new best practice guidelines, for example for the management of respiratory disorders. Our review of the practice meeting minutes confirmed that this happened.

Staff described how they carried out comprehensive assessments which covered all health needs. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met to assist in reducing the need for them to go into hospital. After patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

The GPs we spoke with used national standards for the referral of patients, for example for patients with suspected cancers who were referred and seen within two weeks. The practice was not an outlier for referral rates to secondary and other community care services. The practice reviewed elective and urgent referrals to identify any improvements required.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed 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.

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

Staff from across the practice played a role in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling and medicines management. The information staff collected was then used by the practice to identify clinical audits required. The GPs told us clinical audits were often linked to medicines management information, NICE guidelines or as a result of information from the quality and outcomes framework (QOF). (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).

The practice had a system in place for completing clinical audit. The practice showed us two clinical audits that had been completed. Following each clinical audit, changes to treatment or care were made where needed and a re-audit had been done or there was a date identified for the audit to be repeated to ensure if necessary, outcomes for

patients had improved. For example we saw that an audit had been completed in December 2013 for the fitting of contraceptive coils to confirm if any problems had occurred post fitting, that consent had been obtained and that information had been given on after care and possible complications. The audit confirmed that no actions were required and there was a plan to re-audit again in December 2014.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. QOF data for 2013/2014 showed the practice was performing well in the clinical areas, for example scoring more than 90% in asthma, diabetes, heart failure and chronic obstructive pulmonary disease (lung disease). The data we reviewed showed the practice was not an outlier for any clinical indicators.

The team was making use of clinical audit tools, peer supervision and practice meetings to assess the performance of clinical staff. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Clinical staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

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 evidence we saw confirmed that the GPs and nurses had oversight and a good understanding of best treatment for each patient's needs.

The practice had systems to monitor patients receiving end of life care. It had a palliative care register and had regular internal as well as multidisciplinary team meetings to discuss the care and support needs of these patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example rates for emergency admissions to hospital.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed the training matrix and saw staff were up to date with attending mandatory courses such as basic life support, infection control and safeguarding children. The training matrix outlined what training each member of staff had attended. However it was not clear from the matrix if any refresher training was required and at what intervals this should occur.

All GPs were up to date with their yearly continuing professional development requirements and 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The nurses had also completed training in areas specific to their role, for example diabetes, cervical smears and immunisations. The staff we spoke with confirmed they had access to a range of training that would help them function in their role and the practice was proactive in providing training and funding for relevant courses, for example nurses had attended training in minor illnesses. Staff received appropriate professional development which meant they had the skills and knowledge to care for patients attending the practice.

There was an induction programme in place for new staff which covered generic issues such as fire safety and infection control. Staff told us that role specific induction, for example immunisation training for nurses was available for new staff.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff told us the appraisal was an opportunity to discuss their performance, any training required and any concerns or issues they had.

Good

# Are services effective?

## (for example, treatment is effective)

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

There was a process in place to manage poor performance of staff members.

**Working with colleagues and other services**

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who requested the test or investigation was responsible for reviewing their own results and if they were on holiday the results were sent to the 'duty doctor' for that day. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

There was a system in place to ensure the out of hour's service had access to up-to-date information about patients who were receiving palliative care which helped to ensure that care plans were followed, along with any advance decisions patients had asked to be recorded in their care plan.

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

**Information sharing**

The practice used several electronic systems to communicate with other providers. 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 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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by March 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospitals, to be saved in the system for future reference.

**Consent to care and treatment**

We found that staff were aware of the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Staff had not received MCA awareness training however

all the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions about their treatment and care. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. 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).

Good

# Are services effective?

## (for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for the fitting of contraceptive coils a patient's written consent was obtained and then documented in the electronic patient notes. We saw the consent form outlined the relevant risks, benefits and complications of the procedure and the clinician and patient both signed the form. Staff told us how they explained procedures to patients and checked their understanding before any procedure or treatment was carried out.

**Health promotion and prevention**

It was practice policy for all new patients registering with the practice to complete a health questionnaire to assess their past medical and social histories, care needs and assessment of risk. Patients were then offered a new patient health check. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients were followed up if they had risk factors for disease identified at the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. The practice had a register of patients with dementia and 88.2% had received a face to face review during 2013/2014.

The practice had also identified the smoking status of 86.4% of patients over the age of 15 and had actively signposted 91.5% of these patients to the community based smoking cessation clinics. QOF data for 2013/2014 showed that 96.6% of patients with conditions such as heart disease, stroke**,** hypertension, diabetes, respiratory problems , asthma, and mental health conditions who were recorded as current smokers, had a record of an offer of support and treatment recorded in their records within the preceding 12 months. Performance for smoking cessation support for patients with these conditions was above average for the local CCG area. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 78.9%, which was in line with others in the CCG area. For patients with schizophrenia, bipolar affective disorder and other psychoses, 90% had had a cervical smear in the previous five years. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. The nurses were responsible for following up patients who did not attend for screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for immunisations was above the CCG average for children aged 24 months and slightly below the CCG average for immunisations for children aged 12 months and aged five. Again there was a clear policy for following up non-attenders by the practice. The practice did 'Booster Vaccination Clinics' during school holidays for patients aged 14 to 18 years so young people who had not received required vaccinations during term time could access them whilst on holiday.

There was a good range of health promotion information in the waiting room and on the practice web site. We saw that there were posters around the practice promoting services that may help support patients, such as smoking cessation and support with mental health.

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 national patient survey in 2014 and a survey of 224 patients undertaken by the practice's patient participation group (PPG). The evidence from these sources 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 88% of respondents stated that the last GP they saw or spoke to was good at treating them with care and concern and 92% said the GP was good at listening to them. The satisfaction rates for the nurses for these two areas was 91%.

We received eight completed CQC comment cards and spoke with ten patients during the inspection. All of the feedback was positive about the service experienced. Patients said staff were polite and helpful and always treated them with compassion, dignity and respect.

Staff were familiar with the steps they needed to take to protect patient's dignity. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice had recently restructured the reception area to reduce noise travel. The reception area was open but we observed no confidential information being discussed from the waiting area. There was a room available if patients wished to discuss a matter with the reception staff in private, and there was a notice informing patients that this was available.

We observed reception staff treating patients with respect and being friendly and polite when dealing with requests. Data from the 2014 national patient survey showed 84% of respondents found the reception staff helpful.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

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

The patient survey information we reviewed 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 83% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. The satisfaction rates for the nurses for these two areas were 87% and 93% respectively.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them, they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards and in the national survey 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. There was no notice in the reception area informing patents this service was available. The practice website also had the facility for information to be translated into languages other than English. The new patient page on the website had fact sheets available in various languages that explained the role of UK health services and the National Health Service to newly arrived individuals seeking asylum.

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

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Feedback from the comment cards and the patients we spoke with on the day said they had received help to access support services to help them manage their treatment and care when it had been needed. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Good

# Are services caring?

Notices in the patient waiting room and the practice website also told people how to access a number of support groups and organisations. There was a carers identification form for patients to complete and this included the details of the local York Carers Centre. Written information was available for carers to the various avenues of support available to them, including housing, respite care and benefits. The practice's computer system alerted GPs and nurses if a patient was a carer. The nurses told us that they would signpost patients who were carers to support groups and services that could help them. The nurse told us they monitored patients with long term conditions for anxiety and depression.

Staff told us that if families had suffered bereavement their usual GP contacted them to express their sympathy and offer support. This would be either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find support services.

Information was available to signpost people to support services. This included MIND for help with mental health issues and the Macmillan service.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

We found the practice was responsive to patient'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. For example, following feedback in patient surveys and from the Patient Participation Group (PPG) regarding difficulty getting appointments the practice had recruited two new doctors to increase the number of appointments available.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. For example the practice was participating in the NHS England strategy "Avoiding Unplanned Admissions / Proactive Care Programme Enhanced Services". This was a strategy where the practice would liaise with local health and social care commissioners to work together for people with complex health needs. The practice had identified 105 patients over the age of 75 with complex needs and was working to develop individualised care plans for them.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. For example the practice had introduced the minor illness clinic each morning which was led by the specialist nurses. Less serious conditions were now dealt with promptly by the nurses and, consequently, the GPs had more routine appointment time available. Also feedback in the patient survey said that patients sometimes found it difficult to get through to the practice on the phone. The practice now had an extra member of reception staff on duty at busy times and they were exploring the installation of a new telephone system which would increase the number of phone lines available.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. For example they gave longer appointment times for patients with learning disabilities. The majority of the practice population were English speaking but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. All patients could be involved in decisions about their care.

The practice leased their premises and was based on the ground floor of a modern health centre that housed a pharmacy, dentist and other community health services. All the clinical services in the practice were accessible for patients. However the front door into the main building was not automatic and would pose difficulties for some patients if they came on their own, for example anyone in a wheelchair. The practice manager told us that staff and would assist patients if they were having difficulties opening the door. The consulting rooms were accessible for patients with mobility difficulties and there was also access enabled toilets. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

The practice manager told us how they responded to people who were visiting the area. Because of the location of the practice sites they told us that people who visited the area on holiday would come into the practice requesting to be seen. They said they would treat people in the practice or support them until an ambulance arrived if it was more serious and they needed to go to hospital.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

**Access to the service**

The Petergate surgery was open from 8.30am to 6.00pm Monday to Friday and the Skelton surgery was open 3.00pm to 6.00pm Monday, Tuesday, Thursday and Friday. Patients who did not need an urgent appointment could book them in advance which freed up slots for patients who needed to be seen quickly. The GPs, nurses and receptionists all told us that if patients needed to be seen urgently they were given an appointment the same day.

Comprehensive information for patients about appointments was available in the patient information

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring, depending on the circumstances.

Patients we spoke with and feedback from CQC comment cards and surveys confirmed that patients were able to be seen if they had an urgent need and could get same day appointments. However we found that patients were less satisfied with being able to book routine appointments in advance. Data from the 2013/2014 national patient survey showed 58% of patients described their experience of making an appointment as good. The practice had employed additional doctors and had introduced a nurse led minor illness clinic which had increased the number of GP appointments available. The practice was continuing to monitor patient satisfaction in this area. Reception staff told us they could always offer patients a same day appointment if needed.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available for housebound patients and for those too ill to attend the surgery. Appointments were available outside of school hours for children and young people.

Patients could order repeat prescriptions via their local pharmacy, in person or on line and appointments could be made on the phone, in person or on line. This meant the practice was using different methods to enable patients' choice and ensure accessibility for the different groups of patients the practice served.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The complaints policy had details of who patients should contact and the timescales they would receive a response by.

Information was available to help patients understand the complaints system. Information was displayed in the waiting room, on the practice website and there was a summary in the patient information leaflet. Patients we spoke with told us they would speak with a member of staff if they were not happy with the service. None of the patients we spoke with had ever needed to make a complaint about the practice.

Staff were aware of how to deal with concerns raised by patients and described how they would support someone who was not happy with the service.

The practice had received 11 complaints since February 2014. We saw that these were dealt with in a timely way and had been investigated and satisfactorily handled. We saw that where relevant GPs, nurses and the practice manager had met with the complainant to discuss the issues raised and where possible the complaint had been resolved.

We saw that the practice had received cards and letters thanking staff for their kindness, support and care.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

The practice had a clear vision to promote good health resulting in positive outcomes for patients and to deliver this in a professional and friendly manner. We found details of the vision and practice values were part of the practice's strategy. These values were clearly displayed in the practice and on the website. The doctors, nurses and all other staff were dedicated to offering a professional service and helping to keep patients up to date with news and information about the practice.

We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at 11 of these policies and procedures and saw they had been reviewed within the last 12 months and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding and governance. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice if they had any concerns.

The practice used the Quality and Outcomes Framework (QOF) and data from the CCG to measure its performance. The data for this practice showed it was not an outlier for any clinical indicators. Performance was discussed at the practice meetings and action agreed where necessary to maintain or improve outcomes.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were being used and were effective. For example there were processes in place to frequently review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

We saw evidence that they used data from various sources, including incidents, complaints and audits to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the CCG.

The practice had carried out risk assessments, for example waste management, hazardous substances and fire safety, and action plans had been produced where required. The practice monitored risks on a regular basis to identify any areas that needed addressing. However they did not document the findings.

The practice had completed clinical audits which it used to monitor quality and systems to identify where action should be taken. For example in May 2014 the practice had audited the records of six patients who were being prescribed a patch which administered a painkiller to check that the correct type and dose were been prescribed. The audit identified that improvements were required in both areas. When a re-audit was completed in August 2014 this showed that significant improvements had been made and the practice was prescribing in line with national and local guidelines. The practice did not have a planned audit programme therefore staff undertook audits relating to their individual areas of practice and did not include all staff.

Practice meetings were held weekly which the GPs and practice manager attended. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

**Leadership, openness and transparency**

The practice did not hold formal staff meetings for all staff however staff told us that they had informal meetings each day and these were used for staff to raise concerns and to share information and lessons learned from incidents. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with the practice manager and the GPs. One staff member told us they had raised the issue of no meetings for staff at their appraisal and the practice manager confirmed this discussion had occurred and they were looking at re-introducing staff meetings.

The practice manager was responsible for human resource procedures. We saw that there was an induction procedure in place and there were policies or procedures for disciplinary issues and bullying and harassment. We saw

# Are services well-led?

Good

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

that mechanisms were in place to support staff and promote their positive wellbeing. The staff we spoke with told us they were well supported and the staff worked well as a team.

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

The practice had gathered feedback from patients through the Patient Participation Group (PPG), surveys and complaints received.

The practice had an established a virtual PPG which included membership from a cross section of patients. There was information on the practice website and in the waiting room encouraging patients to become involved in the PPG. We saw the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

There was a suggestion box on the reception desk in the surgery and patients could also provide feedback through the practice website. Forms were also available for patients to complete on the 'Friends & Family' test. We found that the practice was very open to feedback from patients.

The practice had not undertaken any staff surveys but gathered feedback through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

**Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at appraisal records and saw they included a personal development plan. Staff told us that the practice was very supportive of training, for example one nurse told us they had done the minor illness course.

The practice was a training practice for medical students. We spoke with three students and they told us they well supported by the GPs and staff in the practice.

The practice had completed reviews of significant events and other incidents and shared the learning with individual staff members, at the informal daily meetings and via e mails to ensure the practice improved outcomes for patients. For example, a GP had visited a patient at home but was unable to administer the required painkiller as there was none available in their home visit bag. The bag had not been checked when the GP had returned from a period of leave so it had not been identified that the required medicine was not available. The practice introduced a process for checking and updating the contents of the GPs home visit bags.