

Care Quality Commission

Inspection Evidence Table

York Street Health Practice (1-3705684815)

Inspection date: 26 September 2018

Date of data download: 19 September 2018

Safe

Safety systems and processes

Safeguarding	Y/N
There were lead members of staff for safeguarding processes and procedures.	Y
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies were updated and reviewed and accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Y
Information about patients at risk was shared with other agencies in a timely way.	Y
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Y
Disclosure and Barring Service (DBS) checks were undertaken where required	Y
<p>Additional information:</p> <ul style="list-style-type: none">• There were separate adult and children safeguarding leads for the service.• Safeguarding leads check the records of all children's and patients of most concern on a quarterly basis, to ensure they are not missed and information is up to date, in order to provide appropriate support and care.• Safeguarding was discussed across the provider's locations, to ensure a consistent approach and share any learning. (Bevan Healthcare CIC has a service based in Bradford, which also registers similar patients, such as those who are homeless or have substance misuse issues.)• All staff and volunteers received DBS checks and had been identified as to which level was required.• We saw a self-declaration form that employees were asked to complete on an annual basis to declare any criminal investigations, convictions, cautions, reprimands or warnings against them. This had been introduced in April 2018. Copies of completed forms were kept by the provider's human resources (HR) department; which was based at the provider's head office in Bradford.• There were processes in place to support staff if they felt unsafe. For example, alerts were put on patients' record such to identify any areas of risk, such as if a patient was not to be seen alone by a clinician.	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who require medical indemnity insurance had it in place	Y
Additional information: <ul style="list-style-type: none"> • There was a system in place to check the immunisation status of staff. The provider procured the services of a local community trust's occupational health department to support staff. • On the day of inspection, we saw four staff recruitment files and noted they were kept in line with guidance, including references, DBS checks, photo ID. There was a comprehensive induction process to support newly employed staff. • Appropriate General Medical Council and Nursing Medical Council checks of clinical staff were undertaken both on recruitment and an annual basis. 	

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: March 2018	Y
There was a record of equipment calibration Date of last calibration: March 2018	Y
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Y
Fire procedure in place	Y
Fire extinguisher checks	Y
Fire drills and logs	Y
Fire alarm checks	Y
Fire training for staff	Y
Fire marshals	N
Fire risk assessment Date of completion: 29 June 2018	Y
Actions were identified and completed.	Y
Additional information: On the day of inspection: <ul style="list-style-type: none"> • It was not easy to find the fire safety policy on the practice computer system. However, 	

<p>during the day this was rectified making it easily accessible for all staff.</p> <ul style="list-style-type: none"> • When we reviewed the action plan relating to the fire risk assessment, we saw there were outstanding actions. We were informed that the practice had notified the (external to the organisation) person who undertook the fire risk assessment, who would then update the plan accordingly. We spoke with that individual who confirmed completed actions and provided evidence of an updated plan to reflect this. • We were informed that they do not have a designated fire marshal. However, the lead person on duty that day would be in control of ensuring all staff and patients were led to safety in the event of a fire. • The fire alarm was tested on a monthly basis and records were seen to verify this. • A fire drill had taken place on 21 September 2018 and we saw evidence of staff participation in that event. • Staff had access to policies and procedures via the electronic computer system. At the time of inspection, the provider had been using two different electronic document systems, which had caused a delay in being able to easily access some documents on the day. Sight of the appropriate documents were made available post-inspection and found to be in order. • We saw that there was a set of baby-weighing scales that were out of date of calibration. The practice informed us they would take steps to address this. 	
Health and safety Premises/security risk assessment? Date of last assessment: 17 May 2018	Y
Health and safety risk assessment and actions Date of last assessment: 29 June 2018	Y
Additional comments: <ul style="list-style-type: none"> • The service has a contract with an external company to support security of the site. • Gas check certificate 29.8.19 • Electric check certificate 1.5.18 • Legionella check certificate 17.5.18 • On the day of inspection, the practice was awaiting sight of their health and safety risk assessment from June 2018. We saw the communication trail where the practice had repeatedly asked for sight of the assessment. During the inspection the assessment was provided to the practice. We saw there were some identified actions, for example “overloading of an extension lead” and “radiator covers require removing to be cleaned”. The practice informed us the actions would be addressed. • At the time of inspection, it was noted that there were some chemicals kept in the cleaning cupboard that did not have corresponding risk assessments relating to them. We saw evidence post-inspection that this had now been addressed and all non-assessed chemicals removed from the practice. The relevant cleaning staff had been notified to only stock and use those cleaning products which have been appropriately assessed. We saw correspondence from the contracted cleaning company to confirm this and that they would be auditing this henceforth. 	

Infection control	Y/N
Risk assessment and policy in place	Y

<p>Date of last infection control audit: 12 June 2018</p> <p>The practice acted on any issues identified</p> <p>Detail:</p> <p>There was an identified infection prevention and control (IPC) lead who had ensured the actions had been completed in relation to the IPC audit. For example, having daily cleaning charts in the rooms and ensuring the curtains were changed every six months.</p> <p>A hand hygiene audit was undertaken between August and September 2018. Actions identified had been to put up hand-washing posters in the clinical rooms, which had been completed.</p>	Y
The arrangements for managing waste and clinical specimens kept people safe?	Y

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans were developed in line with national guidance.	Y
Staff knew how to respond to emergency situations.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
<p>Explanation of any answers:</p> <p>We saw the protocol on the clinical electronic system which flags up symptoms that have the potential to develop into sepsis by key words, such as temperature, rash, headache. This can identify any potential issues where staff may need to act on sepsis and can alert clinician to act accordingly.</p>	

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers:</p> <p>Clinicians followed up any patients which had been referred and whether they had attended. Any</p>	

non-attenders were followed up, particularly those who were referred through the two-week process.

Appropriate and safe use of medicines

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)	1.01	0.94	0.95	Comparable with other practices
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2017 to 30/06/2018) (NHSBSA)	3.6%	6.2%	8.7%	Variation (positive)

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	N/A
Up-to-date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Y
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y

Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y
Additional information: <ul style="list-style-type: none"> On the day of inspection, it was noted that the practice did not record the serial numbers of the blank prescriptions which came into the practice. We were informed they would review the arrangements in line with their handling of prescription stationery standard operating procedure. We saw examples where safe prescribing was undertaken, especially in relation to opioid medicines. For example, one prescription per tablet was given on a daily basis to avoid over-use and ensure compliance for a patient who had a chaotic lifestyle and complex needs. There was evidence to show the practice were one of the lowest prescribers of opioids within the local CCG. There had been an almost 40% reduction within a 12 month period. 	

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y
Staff understood how to report incidents both internally and externally	Y
There was evidence of learning and dissemination of information	Y
Number of events recorded in last 12 months.	27
Number of events that required action	27

Example(s) of significant events recorded and actions by the practice:

Event	Specific action taken
As a result of an analysis of themes from incidents, it had been identified there had been seven incidents relating to prescription issues.	<p>The practice had supported patients to access electronic prescribing.</p> <p>The practice had worked with the substance misuse team to review the processes regarding opioid prescribing.</p> <p>Improved information regarding prescriptions had been made visible in the patient waiting area.</p> <p>Administration staff had been given protected time to concentrate on repeat prescribing.</p> <p>Learning from these incidents had been shared with all staff.</p>
It had been noted that clinical appointment rotas had been inputted on the computer system for when the practice was closed for a training event.	<p>Staff to ensure they are aware of when the practice is closed.</p> <p>Any changes to rotas to be dealt with the responsible person for that task.</p> <p>Days when the practice was closed were made clear to patients through posters/information in the patient waiting area. The practice had ensured that clinical rotas were checked in advance to confirm there was not a training day of that staff were on leave.</p> <p>Learning was shared with all staff.</p>

Safety Alerts	Y/N
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There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y
<p>Comments on systems in place:</p> <p>There was a protocol in place for dealing with Medicines and Healthcare products Regulatory Agency (MHRA) alerts and a link as to where the actions relating to those alerts could be found. However, at the time of inspection we were unable to locate the actioned alerts. We were subsequently informed they had been moved by a member of staff. We raised this as a communication issue and were informed it would be rectified. We did eventually have sight of the actioned alerts.</p> <p>We saw four audits which related to different MHRA alerts which evidenced that actions had been taken. Patients had been identified and treatment changed in line with those alerts and guidance. Patients had been contacted and the rationale for the changes explained to them.</p>	

Effective

Effective needs assessment, care and treatment

Prescribing				
Indicator	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHSBSA)	0.28	0.67	0.83	Variation (positive)

People with long-term conditions

Diabetes Indicators				
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2016 to 31/03/2017) (QOF)	No data available	-		-
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5	No data available	-		-

mmol/l or less (01/04/2016 to 31/03/2017) (QOF)				
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	

Other long-term conditions				
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2016 to 31/03/2017) (QOF)	No data available	-		-
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	No data available	-		-
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (01/04/2016 to 31/03/2017) (QOF)	No data available	-		-
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	
Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy. (01/04/2016 to 31/03/2017) (QOF)	No data available	-		-

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	

Additional information:

The provider had only participated in the Quality and Outcomes Framework (QOF) since April 2018. Therefore, there was no verified or published data available to us on the day of inspection. (The previous provider had not participated with QOF, therefore, there was no comparable data available.)

The provider explained there had been a requirement for them to develop appropriate recall and reporting systems to support the review of patients and the collection of data for QOF. We were shown the data collected between April and September 2018. It was felt it was not appropriate to make any comparisons to local and national averages at the time of inspection, as they had not completed a full year's worth of data.

Outcomes of patients were reviewed using various audits and analysis.

Families, children and young people

Child Immunisation				
Indicator	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2016 to 31/03/2017)(NHS England)	7	7	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2016 to 31/03/2017) (NHS England)	n/a			N/A
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2016 to 31/03/2017) (NHS England)	n/a			N/A
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2016 to 31/03/2017) (NHS England)	n/a			N/A

Additional information:

There were extremely small numbers of children under the age of two years registered at the practice. The ones that were registered were from an asylum seeker background. We were informed that, due to

their circumstances, it was very difficult to ascertain or confirm any previous immunisation history. However, the practice engaged translation services to support with the interpretation of documentation in foreign languages relating to the immunisation status of patients. Immunisations were offered in line with national guidance.

Working age people (including those recently retired and students)

Cancer Indicators				
Indicator	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening who were screened adequately within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64 (01/04/2016 to 31/03/2017) (Public Health England)	No data available	-		N/A
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	No data available	-	-	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	No data available	-	-	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE)	No data available	-	-	N/A
Additional information: We were informed that women were supported to access cervical screening. Information, in an appropriate language, was sent to patients who were of fixed abode. Opportunistic screening was undertaken, especially for those patients who did not have a fixed address and were not easily contactable. All appropriate patients were supported to access other cancer screening services.				

People experiencing poor mental health (including people with dementia)

Mental Health Indicators				
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	No data available	-		-
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	
Indicator	Practice	CCG	England	England

		average	average	comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) <small>(QOF)</small>	No data available	-		-
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) <small>(QOF)</small>	No data available	-		-
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	
Additional information: All patients who were suspected of developing dementia were assessed and referred to an appropriate clinician. They were reviewed in the practice and supported as needed.				

Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	No data available	-	-
Overall QOF exception reporting (all domains)	No data available	-	-

Coordinating care and treatment

Indicator	Y/N
There were regular (at least 3 monthly) multidisciplinary case review meetings held where all patients on the palliative care register were discussed (01/04/2016 to 31/03/2017) (QOF)	Y

Helping patients to live healthier lives

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with physical and/or mental health conditions whose notes record	No data available	-		-

smoking status in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)				
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	()	0.0%	0.0%	

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately
Patients sign a consent form when registering. Consent was discussed, as appropriate, with patients during consultations.

Any additional evidence
We saw that thematic analysis had been undertaken relating to deaths of patients. Lessons learned from the analysis, included better use of the end of life template to record a patients' wishes and their next of kin.

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	5
Number of CQC comments received which were positive about the service	4
Number of comments cards received which were mixed about the service	1
Number of CQC comments received which were negative about the service	0

Examples of feedback received:

Source	Feedback
CQC patient comment cards	Patients gave us examples of how they had been supported by staff at the practice. They said they were kind, caring and respectful.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

Practice	Surveys sent out	Surveys returned	Survey	% of practice
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population size			Response rate%	population
1630	389	25	6.4%	1.53%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	87.1%	89.4%	89.0%	Comparable with other practices
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	87.1%	88.0%	87.4%	Comparable with other practices
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	89.4%	95.4%	95.6%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	88.3%	84.9%	83.8%	Comparable with other practices

Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Interviews with patients.	Patients said they felt involved in decisions about their care and treatment.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	94.5%	94.0%	93.5%	Comparable with other practices

Question	Y/N
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified	<p>19 carers were identified. This equated to approximately 1% of the patient population.</p> <p>However, patients were more likely to be supported themselves, rather than be a carer.</p> <p>We obtained the numbers of patients who had a recorded support worker, which was 153.</p> <p>The number of patients who had a carer themselves was 15.</p>
How the practice supports carers	Carers were supported by practice staff as their need arose. They were patients in the practice and had access to clinicians.
How the practice supports recently bereaved patients	Patients were offered support as was needed.

Any additional evidence
<ul style="list-style-type: none"> • A chaperone policy was available both in the practice and on the website. • Patients were asked for details of their allocated support worker, which is identified on their record. • Patient satisfaction levels as indicated in the national patient survey had improved from previous years' results.

Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y

	Narrative
Arrangements to ensure confidentiality at the reception desk	<p>Patients could not be easily overheard at the reception desk.</p> <p>There was an area away from the desk should confidentiality be compromised.</p>

Question	Y/N
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y

Responsive

Responding to and meeting people's needs

Practice Opening Times	
Day	Time
Monday	08:00 to 18:00
Tuesday	08:00 to 18:00
Wednesday	08:00 to 18:00
Thursday	08:00 to 18:00
Friday	08:00 to 18:00

Appointments were available during these times, with patients being able to access care and support as needed.
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Home visits	Y/N
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Y
If yes, describe how this was done	
Home visits were not generally requested, due to the patient demographics. However, should the need arise we were assured a clinician would visit.	
Any additional evidence	
It was noted that the majority of patients were classed as high risk due to the complexity of their circumstances. However, there were approximately 20 patients who were extremely high risk who they 'did not turn away' in line with their protocol.	
The provider operated a 'street medicine bus', which was available for York Street Health Practice to be used two evenings per week in Leeds city centre.	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1630	389	25	6.4%	1.53%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	96.7%	95.3%	94.8%	Comparable with other practices

Timely access to the service

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	95.7%	74.4%	70.3%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	100.0%	68.9%	68.6%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	91.3%	67.3%	65.9%	Variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	76.9%	73.7%	74.4%	Comparable with other practices

Examples of feedback received from patients:

Source	Feedback
Patients	Patient said they could get an appointment or access to a clinician when they wanted one during the practice opening hours.

Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	2
Number of complaints we examined	2
Number of complaints we examined that were satisfactorily handled in a timely way	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman	0

Additional comments:

- A complaints policy was available in the practice and on the website.
- CQC had also received a complaint. This was discussed with the practice who informed us they were aware of the issues and were dealing with them.

Example of how quality has improved in response to complaints

We reviewed a complaint which related to a patient appointment being booked with a member of staff who was on leave. As a result, the system had been amended to ensure all staff rotas and leave were easily seen by staff when making patient appointments, to ensure this type of error was not made again.

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice

- Leaders were accessible and visible in the practice. Staff knew how to access managers should the need arise.
- On the day of inspection, we were informed of the challenges and priorities relating to the service.

Vision and strategy

Practice Vision and values

There was a provider vision which was cascaded down to practice and staff level. This was to provide “a responsive organisation promoting high quality health and social care for the most vulnerable members of society”.

The provider (practice) was part of the faculty of inclusion health and homelessness and promoted “health, hope and humanity” as its vision and strapline.

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care

There was a culture of providing high-quality sustainable care. The provider also had a practice in the Bradford area which had previously been inspected and rated highly by CQC. We were informed of the aims and objectives of the provider to support York Street Health Practice to achieve a similar rating. However, they acknowledged that since they had taken over the practice, there had been challenges that had prevented them developing the service as much as they had planned.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
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Staff	Managers, clinicians and members of staff told us how they felt supported to deliver care to their patients. There were regular meetings where staff had an arena to voice any concerns or ideas to support service delivery and patient care.
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Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies and processes	An induction process was in place for newly recruited staff. Appraisal of staff where performance could be monitored and addressed. Business continuity plan was in place. There was an agreement with a local practice whereby the practice could co-locate in an emergency, should the need arise.
Practice meetings	There was a range of clinical and non-clinical meetings to support a good understanding of service delivery.
Y/N	
Staff were able to describe the governance arrangements	Y
Staff were clear on their roles and responsibilities	Y

Managing risks, issues and performance

Major incident planning	Y/N
Major incident plan in place	Y
Staff trained in preparation for major incident	Y

Examples of actions taken to address risks identified within the practice

Risk	Example of risk management activities
Assessments	Health and Safety Premises security Lone worker

Any additional evidence
The practice had needed to refer an individual to a safe haven practice (a practice for patients not appropriate for general practice). The person had been exhibiting threatening and aggressive behaviour towards staff. They were not a patient registered with the York Street Health Practice. The police were subsequently called to deal with the situation. It was found there were effective systems in place at the time of the incident to keep staff and patients, who were in the practice, safe.

Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group (PPG):

Feedback
The practice had invited members of the PPG to attend on the day of inspection to speak with us. However, unfortunately there was a non-attendance of any members. We were informed there were difficulties in maintaining a regular PPG. However, there was a date planned for October 2018.

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
In relation to recent Medicines and Healthcare Products Regulatory Agency (MHRA) patient safety alerts	We saw four audits which related to different MHRA alerts which evidenced that patients had been identified and treatment changed in line with those alerts and guidance. Patients had been contacted and the rationale for the changes explained to them.
Long-term condition reviews	We saw audits which related to patient reviews of long-term conditions, such as diabetes and asthma. These were retrospective audits to establish how many reviews had been undertaken prior to the provider taking over the practice and how many had been completed in a 12 month period. We saw there had been improvements, however, the practice acknowledged there was still some work to be done to ensure all the reviews were undertaken in line with guidance. These audits were due to be repeated to assess progress. We saw action plans in relation to the audits.

Any additional evidence
<p>Since taking over the practice, the provider had instigated a programme of audit. We were shown many audits relating to the care, treatment and review of patients, in line with local and national guidance. We were provided with evidence, which could supported how improvements were being made. At the time of our inspection many of the audits were single cycle with a re-audit date identified.</p> <p>The provider informed us there had been significant staff changes since they had taken over the practice, which had caused them to not have completed the reviews of patients in the timescales they had initially set themselves.</p> <p>The provider had a similar practice in Bradford and any learning from audit, incidents, complaints was shared across both practices.</p>

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still

shows as comparable, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as comparable to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	Comparable to other practices	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment. ([See NHS Choices for more details](#)).