

# Care Quality Commission

## Inspection Evidence Table

Dalton Terrace Surgery

(1-573771800)

### Inspection Date:

Date of data download: 19/10/2023

## Context

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the ninth lowest decile (9 out of 10). The lower the decile, the more deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is predominantly White. There are approximately 9.5k patients registered with the practice.

At the time of inspection, the practice reported a steady increase in the practice population. Since the last inspection in 2015 the practice population had increased by approximately 2k. The practice had experienced recent challenges for the recruitment of a GP to cover maternity leave. They reported they were now in a much better position in terms of clinical staffing. Difficulties recruiting to non-clinical staff vacancies was also reported.

## Overall rating: Requires improvement

### Safe

### Rating: Inadequate

At the last inspection in November 2015 the safe key question was rated as good. At this inspection we rated the practice as inadequate for providing safe services because:

- The practice did not have clear systems, practices, and processes to keep people safe and safeguarded from abuse.
- Appropriate standards of cleanliness and hygiene were met. However, the processes for managing IPC were not always well managed.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- Staff did not always have the information they needed to deliver safe care and treatment.
- The practice had ineffective systems for the appropriate and safe use of medicines, including medicines optimisation.
- The practice did not have a consistent and effective system to learn and make improvements when things went wrong.

## Safety systems and processes

**The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
Partners and staff were trained to appropriate levels for their role.	P
There was active and appropriate engagement in local safeguarding processes.	P
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	P
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice safeguarding lead attended regular Integrated Care Board (ICB) GP Safeguarding Practice Lead meetings. Safeguarding was not a standing agenda item at the weekly practice meetings.</p> <p>We noted in the ICB GP safeguarding practice lead meeting minutes in December 2022 that practices were encouraged to complete the Humber and North Yorkshire ICB GP Safeguarding Standards for Adults and Children audit. This was again referenced in the May 2023 minutes. The records showed the provider had completed the audit in October 2023. The last audit completed which the provider shared was dated 2018.</p> <p>The audit findings included 31 areas, of which 18 were marked as green, 8 as amber/green, 4 as amber and 1 as amber/red. Examples where improvement was required included:</p> <ul style="list-style-type: none"><li>• Completion of female genital mutilation (FGM) training for staff</li><li>• Completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs).</li><li>• Consider having dedicated safeguarding agenda item in each quarterly Partners Meeting.</li><li>• Check that the practice ensured that clinical records clearly indicated that a child had a Child Protection Plan or Child in Need Plan and an annual audit process for checking the maintenance of the list.</li><li>• Check that the maintenance of clinical records was accurate in respect of Child Protection Plans or Child in Need Plan through yearly audits since the change in clinical systems.</li></ul> <p>There was no monitoring in place to ensure completion of actions identified in the audit.</p> <p>We were told that a report of children that were not brought for appointments was produced and shared each month with the safeguarding lead. We were not provided with any safeguarding audits or record checks that had been completed.</p>	

We checked one patient record and saw they were appropriately coded to identify them as a person safeguarded.

We asked the provider about a certain group of patients and any children who resided or were associated with them who maybe at increased risk of harm or may have already been subject to harm. We were told these known individuals were not coded as at risk on the clinical system which meant they would not be flagged to staff if they were in contact with the practice. We were told the patients were known to them and so they were not all flagged. This created a risk that new staff including locum staff would not identify such people and manage such risk appropriately.

Not all staff had completed the minimum safeguarding training requirements set out in the Royal College Intercollegiate guidance. Staff showed a lack of understanding in respect of the level of training nursing staff should complete. Training had not been flagged as an issue on the recent audit completed.

- 8 out of 11 (73%) GPs had completed safeguarding children and adults training to the appropriate level, 3 of whom had completed it during the inspection announcement period.
- All other clinical staff had completed safeguarding training. However, most of the nursing team were not trained to the appropriate level for adults and children.
- 16 out of 18 non-clinical staff had completed safeguarding adults training and 17 out of 18 completed safeguarding children.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	P
Explanation of any answers and additional evidence:  We looked at the recruitment records of four members of staff. <ul style="list-style-type: none"><li>• For one clinical staff member, the employment contract was not signed or dated by the employer or employee. We were told after the inspection that the employment contract was with The British Medical Association (BMA) for checking.</li><li>• For one clinical staff member, the DBS was related to a check carried out for a different role at a different health setting. The DBS check was recent. There was no evidence the Performers List had been checked and no risk assessment in place in respect of the suitability of accepting the DBS check.</li><li>• A full record of immunisations was in place for two members of clinical staff. These had been completed at a previous place of employment. The other two clinical records showed no record for 1 and a record of COVID-19 vaccination only for the other. The recruitment check list referenced checking for Hepatitis B but this was not completed for both.</li></ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 03/10/2023	
There was a fire procedure.	Y
Date of fire risk assessment: 07/07/2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Fire evacuation drills were completed regularly, and actions noted.</p> <p>Not all staff had completed fire safety training in line with the timescale set by the provider.</p> <ul style="list-style-type: none"> <li>71% of all practice staff had completed fire safety training.</li> </ul> <p>Five 'high' risk actions were identified and formed part of the fire risk assessment action plan assessed by an external specialist. 4 out of 5 of the actions had been completed. The 1 remaining action had been risk assessed by practice management and not actioned as this was assessed as increasing the risk of trips and falls for patients.</p>	

### Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met. However, the processes for managing IPC were not always well managed.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 17/03/2022 and 19/10/2023	
The practice had acted on any issues identified in infection prevention and control audits.	P
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a lack of clarity from staff as to who the IPC lead was, either the lead nurse or the practice manager was referenced. Neither of them had completed any additional training to support them in their role.</p> <p>Not all staff had completed IPC training in line with the timescale set by the provider:</p> <ul style="list-style-type: none"> <li>79% of all practice staff completed.</li> <li>45% of GPs had completed.</li> <li>80% of other clinical staff completed.</li> </ul>	

- 100% of administration staff completed.

Systems were in place for staff to check the expiry dates of single use items used in clinical rooms. Audits to ensure such checks were carried out were not completed. A random sample of such items showed almost all items to be satisfactory. Those not, were brought to the attention of a staff member and removed from use.

The premises were observed to be clean and tidy.

An IPC audit had recently been completed. A list of actions which included the replacement/repair of some blinds in clinical rooms, fixing soap dispensers to walls in consulting rooms and replacing consulting room sinks. The provider confirmed these would be actioned by February 2024.

## Risks to patients

**There were gaps in systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	P
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
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.	P
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider told us they felt they had responded well to a recent medical emergency within the practice. They had noted this as a significant event.</p> <p>Not all staff were suitably trained in emergency procedures in line with the timescale set by the provider:</p> <ul style="list-style-type: none"> <li>• 62% of all practice staff had completed basic life support training.</li> <li>• 55% of GPs had completed anaphylaxis training.</li> <li>• 60% of nurses had completed anaphylaxis training.</li> <li>• 27% of GPs, 100% of nurses and 83% of administrative staff had completed sepsis training.</li> </ul> <p>Information about the emergency medicines held by the practice at the time of the inspection visit is in Medicines management (below).</p>	

## Information to deliver safe care and treatment

**Staff did not always have the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	N
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	P
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	P
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
<p>Explanation of any answers and additional evidence:</p> <p>Our review of patient records in relation to the clinical searches identified that care records were not always managed in a way to protect patients. For example, shared care documents and results were not always stored appropriately on the patient's clinical record, there were delays to filing and closing down letters and results in the practice workflow in-box and medication reviews lacked detail to demonstrate what had been discussed and measures put in place as part of the review.</p> <p>The provider did not have a policy for summarising patient records. Staff were allocated to the role of summarising patient records. 34 patient notes that required summarising dated back to 4 February 2020. Practice management was not aware of this until identified as part of the inspection process. They informed us they were investigating this.</p> <p>Test results were sent to the patients' named GP with a buddy system in place when not available. Individuals and buddies were responsible for their own actions with no overall oversight at management level.</p> <p>Our search of some clinical workflows which included pathology results and letters received electronically into the practice identified the following:</p> <ul style="list-style-type: none"> <li>• A significant number of letters received from over a month ago had not been filed. By the practices own admission on the 7.11.2023 via e-mail they confirmed they were behind with managing non-urgent correspondence due to annual leave and unplanned absence.</li> <li>• We viewed a significant number of pathology results in the practice pathology in-box dating back to 31 August 2023.</li> <li>• One abnormal test result dating back to 26 September and 6 for the week prior to the inspection start date were listed within the pathology test result in-box.</li> </ul> <p>It was not clear whether these had been actioned and viewed appropriately.</p>	

## Appropriate and safe use of medicines

### The practice had ineffective systems for the appropriate and safe use of medicines, including medicines optimisation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.68	0.85	0.91	Tending towards variation (positive)
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). (01/07/2022 to 30/06/2023) (NHSBSA)	3.6%	4.4%	7.8%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	4.91	4.84	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	84.9‰	116.0‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.31	0.30	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	5.3‰	4.3‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	N
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	P



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.	N
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	P
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	N
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	P
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	N
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>Processes were not in place to manage and ensure the safe storage of controlled stationery. Blank prescriptions were left in printers overnight with no additional measures in place for locum usage. We were told the risk of this had been assessed as nil as the printers were in locked rooms. No risk assessment was in place to support this decision in line with NHS Counter Fraud Authority: management and control of prescription forms: A guide for prescribers and health organisations (March 2018). There were several incidences on the prescription log where the date of issue, who it was issued to, and the signature were blank. Two incidences in recent weeks showed 2 batches of prescriptions had been destroyed. The reason for this destruction was not recorded. When asked we were told it was because they had been found by staff in drawers in clinical rooms. We found one patient specific prescription on the top of a printer. This was passed to management. There was a risk that if theft occurred the practice would be unable to determine the scale of the theft.</p> <p>We identified concerns in the management of appropriate authorisations to administer medicines. (including Patient Group Directions (PGDs) or Patient Specific Directions (PSDs). Three PGDs were not signed by an authorising manager. A member of the management team was made aware.</p> <p>The practice could not demonstrate the prescribing competence of the non-medical prescriber. We were told there was no regular review of their prescribing practice, and this was something to be reviewed and put in place. No evidence was available in the staff members employment record or in their recent annual appraisal.</p> <p>The provider was not able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. The provider informed us they had recognised for some time that a more robust process was needed for calling patients in for review. They said that patients were generally reviewed when they made a medication request, usually when a medication was overdue. They said it was reactive rather than proactive with not all required patients being on a recall system. We noted in minutes of</p>	



practice meetings in March 2023 that the need for a list of blood tests for recall needed to be focused on with a system of recall to support this. This was noted again in September 2023 as still requiring action. We were told that a non-clinical role as part of the Primary Care Network staff was being recruited to take on the role of recalls from GP's. The lack of recall for some conditions was indicative of the findings below. These included:

The provider recorded medicine reviews had been conducted without always documenting the outcomes from the review and without always addressing required monitoring or changes to treatment that should have been identified during a comprehensive review. The review did not show all documentation about the review.

We looked at the way patients prescribed specific high-risk medicines were managed. In particular:

We reviewed patients prescribed the medicine Methotrexate - Methotrexate is a type of medicine called an immunosuppressant. It slows down the body's immune system and helps reduce swelling (inflammation). In the last 6 months 37 patients had been prescribed the medicine. Of the 37, 6 (16%) had potentially not had the required monitoring (should be every 12 weeks but our search identifies patients over 6 months) required when prescribed this medicine. We looked in detail at 5 of these patients records and identified the following issues:

- Blood test monitoring was not up to date for all patients. provider informed us there was no recall process in place for patients review and that this was done opportunistically.
- The patient was not always instructed to take their medicine on the same day each week.
- Documentation received from specialists/community clinics as part of shared care agreements was not always considered, in place and easily accessible on the patient's clinical record.

We reviewed patients prescribed the medicines Angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs). These are medicines that widen blood vessels and so, lower blood pressure. They can treat high blood pressure, and heart and kidney problems.

Of the 1032 patients prescribed ACE inhibitor or Angiotensin II receptor blocker, our searches indicated 52 (5%) had not had the required 12 month monitoring in the last 18 months. We looked in detail at 5 of these patient records and identified the following issues:

- 2 patients overdue monitoring.
- 1 patient required monitoring blood test. This was documented in specialist letter. The practice had not always considered and documented results received from specialists/community clinics.
- 2 patients were on the repeat medication list but had not been issued the medication recently as not requested. Their records had not been updated.

We reviewed the numbers of patients prescribed DOACs - Direct-acting Oral Anti-Coagulants - blood thinning medicines. Our searches indicated 251 patients had been prescribed this medicine. Our searches indicated that 49 (19.5%) of these patients had not had calculation of the creatinine clearance in the last year and 30 patients (12%) had never had this done. The choice of DOAC dose is guided by creatinine clearance. We did not look specifically into a sample of patient clinical records.

We reviewed the number of patients over 70 years of age, prescribed Nonsteroidal anti-inflammatory drugs (NSAIDs) or antiplatelet and not prescribed a proton-pump inhibitor (PPI). 114 patients were identified. We reviewed 3 patients over the age of 75 years clinical records in detail. They did not identify any reason why a PPI was not prescribed which may have benefited the patient and reduced adverse side effects.

Following our feedback to the provider regarding the clinical search findings the provider acted promptly on the information provided to them. An explanation was provided for some of the results and practice staff had been allocated areas to review the processes and patients impacted. Immediate actions and long-term plans to deliver improvement were reported to us.

We reviewed the number of patients prescribed 10 or more prescriptions for benzodiazepines or Z drugs. These are medicines prescribed for short-term relief. Long term use can lead to further health issues. No patients issued more than 10 prescriptions were identified in our search. The provider informed us that they had carried out a piece of work to improve prescribing and patient care in this area.

Controlled drugs were stored on the premises. They were stored and recorded appropriately as awaiting disposal and collection, as part of local arrangements external to the practice. It had been a considerable amount of time since this was requested and not subsequently followed up. We raised this with a member of staff who informed us they would raise this and request collection again immediately.

Emergency equipment and medicine checks were not always carried out. Records showed a total of 32 individual days during the period May 2023 to the date of the inspection site-visit when daily checks had not taken place. When checks were carried out, they did not always identify when there were issues. For example, we identified three emergency medicines past their expiry date.

Vaccines stored in fridges were within their expiry date. Internal and external temperature devices were used. The practice was not ensuring they maintained the cold chain storage for medicines. There were gaps in recording, which meant they did not know what temperatures the medicines had been stored at and when the temperature did go out of range. Staff did not act or understand what action to take to ensure medicines were safe and effective to use. There was no practice policy in respect of this.

#### Track record on safety and lessons learned and improvements made

**The practice did not have a consistent and effective system to learn and make improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	P
Staff knew how to identify and report concerns, safety incidents and near misses.	P
There was a system for recording and acting on significant events.	N
Staff understood how to raise concerns and report incidents both internally and externally.	P

There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	14
Number of events that required action:	13
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have a consistent and effective system to learn and make improvements when things went wrong. Significant events were not managed in a consistent and effective way to demonstrate thorough investigation, monitoring and action taken to prevent further occurrence. Wider sharing of learning within the practice was lacking.</p> <p>Feedback from staff in respect of their understanding and how they would report a significant event was not consistent. This was supported by the differing forms staff had completed which we saw in the records submitted to us and viewed during the inspection site visit.</p> <p>The practice had an electronic log of significant events. This did not correspond with the paper records held. Whilst there was some evidence of learning, for some significant events there was no information as to whether actions had been completed and whether or how the learning had been shared. Some appeared to be logged as part of annual GP clinical appraisal and learning noted for the individual only and not for wider sharing and learning within the practice. There was clear evidence that learning across the wider staff group would have benefited the practice staff.</p> <p>We noted some complaints had been considered as significant events but others that had not. For example, a complaint regarding a breach of patient's physical privacy had not been considered as a significant event. We also noted that significant events discussed at the weekly practice meeting were not logged on the log. For example, in the minutes in May 2023 two incidents were discussed but these were not evident on the log.</p> <p>Significant events were not a standing agenda item at practice meetings. Actions agreed, if any, were not consistently recorded or reviewed at the next meeting to ensure action had been taken. We were told there was no documented system to review if there were themes in significant events or to confirm actions taken were effective. Most entries on the log stated further action as 'none'.</p> <p>The provider had a significant/critical event toolkit which had a review date of October 2023. The above findings did not correspond with what the provider had stated would happen in the toolkit.</p>	

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

Event	Specific action taken
GP unaware of updated blood pressure/pulse readings	Remind reception to task GPs once blood pressure coded; reception to average pulse rates if provided and task GP's; blood pressure sheets to be scanned on contemporaneously?  Discussed at team meeting and minutes circulated. No further action noted.
Whilst considered, missed Addison's disease.	Discussed at Practice Meeting; further discussion with team at York Hospital leading to amendments to process for diagnosing Addison's disease.
Inappropriate prescribing of amber drug.	To be advised

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have a policy for managing safety alerts. We were told there was a process for disseminating and recording alerts and that periodic checks were made to oversee they had been actioned. However, from our clinical searches the provider was unable to demonstrate that all relevant safety alerts had been responded to.</p> <ul style="list-style-type: none"> <li>In November 2019, The Medicines and Healthcare products Regulatory Agency (MHRA) issued a Drug Safety Update detailing the rare but serious and potentially life-threatening risk of Fournier's gangrene with SGLT-2 inhibitors. A review of 5 patient clinical records showed no documented evidence of advising 4 patients about rare but serious risk of Fournier's gangrene.</li> <li>In 2020 a Drug Safety Update advised that prescribers should inform the patient the medicine Methotrexate should be taken on the same day each week and recorded in the patient's clinical record. A review of patient's clinical records showed this was not always recorded.</li> </ul>	

## Effective

## Rating: Requires improvement

At the last inspection in November 2015 the effective key question was rated as good. At this inspection we rated the practice as requires improvement for providing effective services because:

- Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- There was evidence of quality improvement activity, but it had not always been coordinated to ensure that it led to improvement in the quality of care. Audits had not identified the issues found as part of the inspection.
- The practice was not able to consistently demonstrate that staff had the skills, knowledge, and experience to carry out their roles.
- Staff did not always work together and with other organisations to deliver effective care and treatment.
- The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

*QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

### Effective needs assessment, care and treatment

**Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	P
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	P
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y

The practice prioritised care for their most clinically vulnerable patients.	P
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us they kept up to date with current evidence-based practice.</p> <p>During our remote clinical search of patient records, we found evidence which demonstrated the practice was not consistent in ensuring that all patients including those clinically vulnerable had been followed up or provided with regular reviews. The provider acknowledged they needed to consider their recall arrangements to ensure they were proactive in reviewing patients who were not currently called for regular review.</p>	

## Effective care for the practice population

### Findings

- We were informed by the provider that health checks for patients were carried out opportunistically rather than proactively. Frail patients were not coded, for easy identification by staff and reviews were opportunistic.
- Flu, shingles, and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to NHS checks for patients aged 40 to 74 via an external provider. 2741 patients were eligible. 948 had been invited and 140 checks had been carried out in the last 12 months.
- Patients with a learning disability were offered an annual health check. 41 out of 45 patients had been offered a health check. 32 had been carried out. Since we were initially provided with the information, 1 additional patient had been invited for their review. The other 3 were due for review early next year.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice provided weekly ward rounds to the local care provisions they supported.

## Management of people with long term conditions

### Findings

We were informed systems were in place to recall patients to the practice for routine reviews for asthma, chronic obstructive pulmonary disease (COPD), diabetes, and ongoing prostate-specific antigen (PSA) monitoring.

We identified concerns with the way patients with asthma were followed up to ensure they received appropriate care.

- A total of 34 (3.1%) out of 1087 patients were identified as having been prescribed 2 or more courses of rescue steroids. We reviewed 5 patient clinical records in detail. We found in 4 out of the 5 records that patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care.

Our search of clinical records in respect of patients with certain long-term conditions such as Diabetes, Chronic kidney disease and Hypothyroidism showed majority of patients received good level of care.

- Our searches indicated a total of 9 (2.5%) out of 360 patients with hypothyroidism had not had the required thyroid function test monitoring for this condition for 18 months. We reviewed 5 patient clinical records in detail. The records confirmed no recent blood test result for 3 patients. Blood test invitations had been documented for 2 of these patients. Blood test results for 1 patient was found in a hospital letter and 1 patient had refused blood tests. We shared specific patient detail for 1 of the 5 patients that required more urgent action to review due to evidence of potential patient harm. 3 medication reviews had been carried out for these patients, 2 were coded as a medication review but with minimal details about the review recorded.
- Our searches indicated a total of 9 patients out of 424 patients with Chronic Kidney Disease Stages 4 or 5 had not had specific monitoring in the last 9 months. We reviewed 2 patient clinical records in detail. Whilst the records confirmed they were receiving specialist care; the review identified the practice was not always considering and or recording information received from specialists/community clinics on the patient's clinical record.
- Our searches indicated a total of 21 (5.4%) of patients with diabetic retinopathy who's latest HbA1c was >74mmol/l. We reviewed 5 patient records in detail and found appropriate checks and monitoring of diabetic patients.
- A total of 5 patients were identified by search as having a potential missed diagnosis of diabetes. We reviewed 4 patient clinical records in detail. We found no concerns with the way these patients were monitored and managed.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

Adults with newly diagnosed cardio-vascular disease were offered statins.

Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	78	81	96.3%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	80	84	95.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e.	79	84	94.0%	Met 90% minimum



received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	81	84	96.4%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	86	90	95.6%	Met 95% WHO based target

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	69.3%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	76.4%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA)	77.0%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	66.7%	51.0%	54.9%	No statistical variation

Any additional evidence or comments
Records showed there were timely appointments available for cervical cancer screening. An additional member of staff was undertaking training to be able to carry out screening which would further increase capacity at the practice.

## Monitoring care and treatment

**There was evidence of quality improvement activity, but it had not always been coordinated to ensure that it led to improvement in the quality of care. Audits had not identified the issues identified as part of the inspection.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N

## Any additional evidence or comments

The provider told us they did not have a programme of targeted quality improvement. Audits seen that referenced re-audit were not planned for future completion.

We asked the practice for clinical audits or improvement activity in the last 2 years.

We were provided with the following records:

- July – October 2023 – in-house medication audit. The aim of the audit was to review the type of medication that was kept at the practice, to confirm where medication was kept and to reduce medication waste. The audit confirm re-audit was necessary in 6 – 12 months but no date planned.
- August 2023 - Hypertension Case Finding audit conducted as part of staff member external qualification. Findings demonstrated improved outcomes for patients. The audit referenced re-audit. No planned date for this was recorded.
- January 2022 – November 2022 - Cancer referral audit. Improved safety netting for 2 week-wait referrals and information sharing evident from the audit.
- January 2021 and November 2022 – audit of change of document processing to ensure letters coded and forwarded appropriately within the practice. As part of the November 2022 audit, it was identified that checking the letters not forwarded to GPs by administrative staff was still outstanding and would be performed in the next 3 months. There was no evidence provided to show this had been completed or was planned.
- We were told audits in respect of Long-acting reversible contraception (LARC) completion rates, specific medicine audit following a complaint and reducing prescriptions of addictive drugs had been conducted. We did not see these records. However, we did see evidence from our clinical searches of reduced prescribing of certain addictive medicines and was told of work that had been carried out in conjunction with secondary care in respect of the way patients with a specific disease was managed which had led to improved management outcomes for patients.

## Effective staffing

**The practice was not able to consistently demonstrate that staff had the skills, knowledge, and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge, and experience to deliver effective care, support and treatment.	P
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision, and revalidation. They were supported to meet the requirements of professional revalidation.	P
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists, and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• We were told by all staff that learning and development was encouraged. Examples were provided of staff members who were supported to develop their skills and move into new or enhanced roles. For example, there was evidence of clinical support/mentoring for a member of staff who was working towards becoming an advanced nurse practitioner and an administrator training to become a nurse.</li><li>• There was evidence that training to support staff in carrying out their specific roles had been completed. However, significant gaps were identified in the training programme set by the provider. Management informed us that a new training programme of mandatory learning had recently been put in place and that it required buy in from all staff.</li><li>• We were told that overtime would be paid to staff who needed to complete training outside of their core working hours.</li><li>• We were told by staff they had completed an induction. Induction records viewed as part of the review of staff personnel records varied. Most related to practical issues relating to issues such as security, fire safety etc. rather than competency type role specific induction.</li><li>• Access to regular appraisals, clinical supervision and revalidation varied. Other clinical staff such as nurses and the health care assistant were appraised by the non-clinical practice manager. There was minimal evidence that clinical supervision, competency assessment or audit fed into this process. Mentor arrangements were in place for the nurse working towards a new qualification.</li><li>• The practice manager had not been appraised for 3 years. The deputy practice manager had been appraised recently but not for some time prior to that.</li><li>• Administrative staff had been appraised.</li><li>• We saw positive feedback from trainees who had undertaken a training placement at the practice.</li></ul>	

### Coordinating care and treatment

**Staff did not always work together and with other organisations to deliver effective care and treatment.**

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	P
Patients received consistent, coordinated, person-centred care when they moved between services.	P
Explanation of any answers and additional evidence:  We received positive feedback regarding the way care was delivered with organisations involved with the practice. However, we identified issues from the patient clinical record searches in respect of the practice arrangements, for documenting and reviewing results from specialists and community clinics. We also identified issues with the way pathology results were managed as referenced under the safe key question.	

### Helping patients to live healthier lives

**Staff were not always consistent and proactive in helping patients to live healthier lives.**

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	P
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	P
Staff discussed changes to care or treatment with patients and their carers as necessary.	P
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:  During our clinical search of patient records we found evidence which demonstrated the practice was not consistent in ensuring that all patients had been followed up or provided with regular reviews, health assessments and checks as required in line with clinical guidance.  We were informed that the role of care coordinators and social prescribers had proven beneficial to patients at staff at the practice.  Health promotion and services were advertised in the practice and on the practice website.	

### Consent to care and treatment

**The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	P
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	P
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	N
<p>Explanation of any answers and additional evidence, including from clinical searches:</p> <p>Feedback from staff demonstrated they understood the requirements relating to consent.</p> <p>Not all staff had completed Mental Capacity Act training in line with the timescale set by the provider:</p> <ul style="list-style-type: none"><li>• 36% of GPs had completed Mental Capacity Act training.</li><li>• 80% of other clinical staff had completed Mental Capacity Act training.</li></ul> <p>Our clinical review of 11 sets of patients' clinical records where a DNACPR decision had been recorded identified concerns with all of them. Examples of Issues included:</p> <ul style="list-style-type: none"><li>• 2 out of the 11 records showed the DNACPR form included in the patient's clinical record and accessible to clinicians who needed it.</li><li>• Gaps in documented reason for the DNACPR decision.</li><li>• Gaps in recording a decision about mental capacity and the outcome.</li><li>• Gaps in review of the DNACPR decision (no review or reviewed when change of circumstances). For example, DNACPR signed whilst the patient was in hospital in 2021.</li></ul>	

## Caring

**Rating: Good**

At the last inspection in November 2015 the caring key question was rated good. This rating remains the same.

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback records from patients was positive about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Patient feedback	
Source	Feedback
Compliment records seen during the inspection site visit	Responsive; above and beyond when dealing with end-of-life care, late appointments offered to relieve anxiety, listened, prompt appointments and actions when phoning, professional and caring.

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	92.2%	87.5%	85.0%	No statistical variation
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 (01/01/2023 to 30/04/2023)	90.4%	86.4%	83.8%	No statistical variation
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 (01/01/2023 to 30/04/2023)	94.2%	94.3%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	90.3%	68.8%	71.3%	Variation (positive)

	Y/N
The practice carries out its own patient survey/patient feedback exercises.	P

### Any additional evidence

The Friends and Family feedback facility was prominently displayed on the practice website.

### Involvement in decisions about care and treatment

#### Staff helped patients to be involved in decisions about care and treatment

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y

Staff helped patients and their carers find further information and access community and advocacy services.	Y
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Source	Feedback
Interviews with patients.	We did not interview patients as part of this inspection.
NHS.uk website (formerly NHS Choices)	<p>Six reviews posted in the last 12 months:</p> <p>3 x 5-star rating – listened to, thorough and empathetic GP's. General thank you for the service provided, caring and superb service.</p> <p>1 x 2-star rating – frosty response when called the practice.</p> <p>2 x 1-star rating – access to management via the telephone.</p> <p>Management responded to positive and negative comments posted on the NHS.uk website. The offer of directly speaking with management was made where negative comments were made or an explanation for the issue given.</p>

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	93.5%	92.1%	90.3%	No statistical variation
				Y/N/Partial
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 other languages and in easy read format.				Y
Information about support groups was available on the practice website.				Y



Carers	Narrative
Percentage and number of carers identified.	260 (approximately 2.7%)
How the practice supported carers (including young carers).	A carers identification policy was in place which covered carers of all ages. Support information was displayed within the practice and on the practice website as well as the facility to register as a carer in person or via the practice website.
How the practice supported recently bereaved patients.	A bereavement policy was in place.

### Privacy and dignity

**The practice respected patients' privacy and dignity.**

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

## Responsive

## Rating: Good

At the last inspection in November 2015 the Responsive key question was rated good. At this inspection we rated the practice as good for providing responsive services because:

- The practice organised and delivered services to meet patients' needs.
- People were able to access care and treatment in a timely way.
- Complaints were listened and responded to. However, investigations and report of actions was not always clear.

### Responding to and meeting people's needs

**The practice mostly organised and delivered services to meet patients' needs.**

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	P
Explanation of any answers and additional evidence:	

Dalton Terrace Surgery operated a personal list system which provided patients with continuity and a consistent level of care.

Patients had access to a broad range of services via the Primary Care Network staff. These included clinical pharmacists, social prescribers, care coordinators and mental health care workers. Patients were navigated to the correct staff member as part of trying to ensure patients were seen by the right person at the right time to help address their need.

The practice new registration form did not ask patients if they had any information or communication needs. This was the initial registration request form. Further information may have been recorded on the patient's clinical record when registered with the practice. We did not review clinical records to confirm this.

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6pm
Tuesday	8am - 6pm
Wednesday	8am - 6pm Extended hours appointments on Wednesdays 6.30pm – 9pm
Thursday	8am - 6pm
Friday	8am - 6pm
Appointments available: individual doctors may vary these times slightly.	
Monday	8.30am – 11pm and 3pm – 5.30pm
Tuesday	8.30am – 11pm and 3pm – 5.30pm
Wednesday	8.30am – 11pm and 3pm – 5.30pm
Thursday	8.30am – 11pm and 3pm – 5.30pm
Friday	8.30am – 11pm and 3pm – 5.30pm

#### Further information about how the practice is responding to the needs of their population

- Vocare was contracted to provide GP cover 6pm to 6.30pm weekdays. Out of Hours 111 covered the period 6.30pm – 8am weekdays and weekends.
- Patients had a named GP who supported them in whatever setting they lived. Each GP at the practice was allocated their own patient list with the aim of providing continuity of care to patients. The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- As part of the NHS's Improving Access to Primary Care Services patients could access an appointment outside of normal practice hours on a Friday 6.30pm – 8pm and on a Saturday 9am – 12pm and 1pm – 5pm. These appointments were available to Dalton Terrace Surgery patients as part of the practice being part of York City Centre PCN. Appointments were available on a five-week rotation at Dalton Terrace Surgery and at other times at Unity Health and Jorvik Gillygate Practice.
- Patients could access blood taking services in the area if appointments were not available at the practice.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Patients requiring longer appointments were supported to do this.

### Access to the service

**People were able to access care and treatment in a timely way.**

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients were able to book appointments in a range of ways including on-line, via the telephone or face to face.</p> <p>The provider had increased practice nurse hours for the past 18 months as well as the health care assistants as they were experiencing an increase in demand for wound dressings.</p>	

## National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	78.2%	N/A	49.6%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	69.7%	51.2%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	75.3%	47.6%	52.8%	Variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	77.8%	70.3%	72.0%	No statistical variation

### Any additional evidence or comments

GP patient survey data reported above was consistently above England average.

We were informed that the right access for patients was kept under constant review. Feedback from others was listened to and actions taken where possible to deliver improvement. For example, additional call handlers had been in put in place to answer the telephones.

The practice had completed a first single audit in February 2023 to try and identify unmet need, improve accessibility, and ensure they were making efficient use of different clinician type. The findings were positive. The audit referenced considering any changes to be adapted and how changes would be sustained in the future. No second-cycle audit had yet been planned.

Source	Feedback
NHS.uk website (formerly NHS Choices)	<p>Six reviews posted in the last 12 months:</p> <p>3 x 5-star rating – good access, listened to, thorough and empathetic GP's. General thank you for the service provided, caring and superb service.</p> <p>1 x 2-star rating – frosty response when called the practice.</p> <p>2 x 1-star rating – access to management via the telephone.</p>

	Management responded to positive and negative comments posted on the NHS.uk website. The offer of directly speaking with management was made where negative comments were made or an explanation for the issue given.
Feedback to CQC	We received no feedback from patients in the last 12 months regarding access to the service.
Care home	Extremely positive about how responsive the practice was and how continuity of care was beneficial and welcoming for patients.
Patient participation group meeting minutes	Access was referenced as a reason why more patients were requesting to move to Dalton Terrace Surgery.

### Listening and learning from concerns and complaints

**Complaints were listened and responded to. However, investigations and report of actions was not always clearly documented.**

Complaints	
Number of complaints received in the last year.	18
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	P
<p>Explanation of any answers and additional evidence:</p> <p>The provider demonstrated that complaints were listened and responded to. However, the recording arrangements to demonstrate investigations and actions was not always clear.</p> <p>A link to an on-line form to make a complaint was available on the practice website.</p> <p>A central system for logging all complaints had been put in place during the inspection announcement period. We were told this had not been in place previously and they would know if there were recurring themes.</p> <p>Complaints were raised by individuals at the weekly practice meeting as and when needed. There was no standing agenda item for complaints. There was some information in the minutes to demonstrate what action was taken, learning and what follow up action was planned. The paper records did not show this level of detail other than what was written in the response letter to the complainant.</p> <p>The complaints log identified 'action taken' and 'learning points. In 11 out of the 18 complaints, learning points was recorded as none. Wider learning and sharing within the practice was minimal. Staff told us that complaints information was only shared with staff involved in the complaint.</p>	

We examined four complaint records. Each record showed the complaint acknowledged and responded to in a timely way. The records held showed a written response to the complainant informing them of the outcome of the complaint. In two out of the four records we found:

- Actions the patient had been told had been taken had not been fully implemented. When we asked for evidence of this the practice confirmed this had not been actioned as indicated to the patient. This was immediately actioned.
- Actions the patient had been told had been taken at the practice did not correspond with internal discussions. There was no documented evidence to show whether this complaint should have been logged as a significant incident.

Example(s) of learning from complaints.

Complaint	Specific action taken
Alleged breach of patient privacy	Action taken – apology made. Incident discussed with GP and nurse involved.  Learning points – possibility of preventing access to room while procedures being carried out.
Care of patient with a certain disease	Complaint taken on by patient's GP. In discussion with secondary care, and in liaison with patient, changes made to way patients with a certain disease were managed.

## Well-led

## Rating: Requires improvement

At the last inspection in November 2015 the Well-led key question was rated good. At this inspection we rated the practice as requires improvement for providing well-led services because:

- Leaders demonstrated they understood the challenges to quality and sustainability. However, the provider was unable to demonstrate that all leaders were always aware of the risks and issues in the service.
- Staff demonstrated they wanted to provide high quality sustainable care. However, this was not supported by a strategy, mission statement or vision and values to enable them to monitor their delivery of high quality, sustainable care.
- The practice had a culture which aimed to deliver high quality sustainable care.
- The overall governance arrangements within the practice were ineffective, resulting in the concerns identified during the CQC inspection.
- The practice did not have clear and effective processes for managing risks, issues, and performance.
- There was some evidence the practice used data and information to support decision making.
- The practice involved the public, staff and external partners to sustain high quality and sustainable care.
- There was some evidence of systems and processes for learning, continuous improvement, and innovation.

## Leadership capacity and capability

Leaders demonstrated they understood the challenges to quality and sustainability. However, the provider was unable to demonstrate that all leaders were always aware of the risks and issues in the service.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:  Leaders demonstrated they understood the challenges to quality and sustainability. However, the provider was unable to demonstrate that all leaders were always aware of the risks and issues in the practice. We were told there was a flat leadership structure at the practice. Where staff had been allocated to lead roles, the governance and oversight in respect of these roles was lacking with limited systems evident to hold each other to account.  The provider informed us they did not have a succession plan in place but that they did have discussions relating to the future.	

## Vision and strategy

**Staff demonstrated they wanted to provide high quality sustainable care. However, this was not supported by a strategy, mission statement or vision and values to enable them to monitor their delivery of high quality, sustainable care.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	P
Progress against delivery of the strategy was monitored.	P
Explanation of any answers and additional evidence:  A member of the management team told us there was no formal mission statement or vision values but there was a belief that the staff team understood and was committed to what Dalton Terrace was trying to do. Those staff who provided feedback to our questionnaire and who answered the question related to the vision and values said they knew what they were. Some staff reported being involved in developing them.  Whilst there was no formal strategy, we saw evidence that quarterly partnership meetings took place where strategy type issues were discussed.	



## Culture

**The practice had a culture which aimed to deliver high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	P
Explanation of any answers and additional evidence:	

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

Source	Feedback
Staff feedback via CQC questionnaires and verbal feedback	Feedback from staff was positive about working at the practice. They described staff as supportive and managers visible. They described a sense of being 'a family'. Staff were proud that they were able to offer a personal list system for their patients. We were told that partners were not always quick to make decisions when linked to departmental change.

## Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	P
There were appropriate governance arrangements with third parties.	N
There are recovery plans in place to manage backlogs of activity and delays to treatment.	P

<p>Explanation of any answers and additional evidence:</p> <p>The overall governance arrangements within the practice were ineffective resulting in the concerns identified during the CQC inspection. The provider was unable to demonstrate that there was clear oversight of governance arrangements to ensure risks to patients, staff and visitors to the practice were considered, managed, and mitigated appropriately.</p> <p>Some policies had not received regular review, had no planned date for next review, had been reviewed during the inspection announcement period or were not in place.</p> <p>Policies were not in place for areas where formal guidance would have improved staff knowledge and governance arrangements. For example, there was no cold chain policy for the management of medicines and no policy for the management of patients who request repeat prescriptions who have not had the relevant blood tests.</p>
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### Managing risks, issues and performance

**The practice did not have clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	P
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	P
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	P
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The management of risks, issues and performance was not always supported by processes to allow this to be effective which resulted in many of the issues identified during the inspection.</p>	

### Appropriate and accurate information

**There was some evidence the practice used data and information to support decision making.**

	Y/N/Partial
Staff used data to monitor and improve performance.	P
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	

There was some evidence the practice used data and information to support decision making. However, the practice did not always document activity or actions they had taken to allow them to demonstrate decision making. For example:

- There was some evidence that data was used to monitor and improve performance. For example, the practice was planning on conducting a further reception survey to further assess demand and patient waiting times.
- Weekly practice meetings did not always demonstrate what decisions were made and what actions were planned to allow them to monitor and review decision making.
- Practice wide sharing of information was not always evident with learning, in some cases, restricted to personal learning only. We were told staff were not provided with themes from complaints and these were shared with individuals only, potentially reducing the opportunity to learn and improve practice performance.

The practice did not always document results received from specialists/community clinics.

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

## Engagement with patients, the public, staff and external partners

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y

The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Facilities for patients to provide feedback were evident within the practice waiting areas. The practice provided evidence to show that where possible they acted on patients' views, including the PPG to improve services. Examples of changes included increasing capacity for reception telephone call handling.</p> <p>The practice had an active PPG who met with clinical and non-clinical representation from the practice. There was evidence of active two-way engagement. Meetings were minuted and actions recorded.</p>	

Feedback from Patient Participation Group.

Feedback
We were unable to obtain feedback from the Patient Participation Group as part of this inspection.

### Continuous improvement and innovation

**There was some evidence of systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	P
<p>Explanation of any answers and additional evidence:</p> <p>A swift and proactive response by the provider to issues identified from clinical searches demonstrated a clear indication to improve. They demonstrated they were recognising existing problems and trying to improve patient's monitoring. Immediate and long-term plans to deliver improvement had been put in place.</p> <p>Learning to make improvements was evident but the systems to ensure this learning was shared practice wide was limited and the systems to monitor the delivery of improvement was lacking. For example, the management of significant events.</p>	

Examples of continuous learning and improvement
<p>The practice had identified a 'Green Champion' who was engaged with the 'Green Practice' courses run by YOR Local Medical Committee (YORLMC) through to the end of 2023. An example of output from this was:</p> <ul style="list-style-type: none"> <li>The practice had provided a collection box for patients to deposit used tablet blister packs for recycling</li> </ul>

## 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 no statistical variation, 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 no statistical variation 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 Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- 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 uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for those aged 25 to 49, and within 5.5 years for those aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

#### **Glossary of terms used in the data.**

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **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.
- ‰ = per thousand.