

Church View Surgery

Quality Report

Denaby Springwell Centre

Doncaster

DN12 4AB

Tel: 01709 863302

Website: Being updated at time of visit

Date of inspection visit: 13 June 2017

Date of publication: 28/07/2017

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	11

Detailed findings from this inspection

Our inspection team	12
Background to Church View Surgery	12
Why we carried out this inspection	12
How we carried out this inspection	12
Detailed findings	14
Action we have told the provider to take	25

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Church View Surgery on 13 June 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Patients told us they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- The process to book appointments had recently been reviewed and patients we spoke with said they found it easy to make an appointment with urgent appointments available the same day. However, we received six CQC comment cards that reported that there was a long wait for routine appointments with a preferred GP.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

- Ensure the process for sending skin/tissue samples for histological examination reflects NHS England Service Specification for Minor Surgery Direct Enhanced Services.

Summary of findings

The areas where the provider should make improvement are:

- Include review of relevant policies and procedures during incident investigation processes.
- Update all locum staff on the chaperone procedure to confirm compliance with the process.

- Monitor attendance at and provide access to regular fire safety training for all staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- From the documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again. However review of the relevant policy or procedure was not always included in the process.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

The practice is rated as requires improvement for providing effective services.

Requires improvement



- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance. However processes were not established for sending tissue removed by minor surgery for histological examination.
- Clinical audits commenced demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care and lower for others. However these results refer to the previous provider.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. However we received six comment cards reporting a long wait to access a routine appointment with a named GP.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from two examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Good



Summary of findings

- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In the examples we reviewed we saw evidence the practice complied with these requirements.
- The lead GP encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice had selected a staff member to engage with patients with a view to establishing a new patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people.

Good



- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. For example, with community matrons.

Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible

People with long term conditions

The practice is rated as good for the care of people with long term conditions.

Good



- Nursing staff had lead roles in long term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was 100% which was 3% above the CCG and 10% above the national average.
- The practice followed up on patients with long term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their

Summary of findings

health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were comparable for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support and signposting to other services for families who experienced bereavement.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours on Tuesday evenings.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

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

- The practice carried out advance care planning for patients living with dementia.
- The practice achieved 98% of the available outcomes for caring for patients living with dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice achieved 78% of the available outcomes caring for patients experiencing poor mental health.
- The practice regularly worked with multidisciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Good



Summary of findings

- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia and were trained dementia friends.
- All patients living with dementia registered at the practice were encouraged to complete the form which was designed to make sure that, if someone was reported missing, the police could access important information about that person as soon as possible. The form contained information about their medical status, mobility, access to transport, places of interest and daily routines. Once completed, copies were made and then available for use if the person should ever be reported missing. The idea is that speedy access to information will help officers track missing people down quickly.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. These results relate to when the location was registered with the Care Quality Commission under the previous provider. Results showed the practice was performing below local and national averages at that time. 291 survey forms were distributed and 100 were returned. This represented 0.2% of the practice's patient list.

- 79% of patients described the overall experience of this GP practice as good compared with the CCG average of 83% and the national average of 85%.
- 64% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.

- 57% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards which were all positive about the standard of care received. For example, comments included 'I feel cared for', the staff are wonderful' and 'I am engaged with my care'. Six less positive comments related to a wait for appointments.

We spoke with five patients during the inspection. All said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Church View Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector and a GP specialist adviser.

Background to Church View Surgery

Church View Surgery is located in Denaby Main, Doncaster. The building is an NHS LIFT building with good parking facilities and disabled access. The community library also occupies the building along with health visitors and the school nursing team.

The practice provide services for 4,128 patients under the terms of the NHS Personal Medical Services contract. The practice catchment area is classed as within the group of the most deprived areas in England. The age profile of the practice population is similar to other GP practices in the area. Of those patients registered at the practice, 63.3% have a long-standing health condition while the national average was 58%.

The practice has a female GP, a salaried female GP and one female regular locum GP. They are supported by an advanced nurse practitioner, an emergency care practitioner, a practice nurse, two health care assistants, two practice managers and a team of administration and reception staff.

The practice is open at Denaby Main from 8.00am to 6.30pm Monday to Friday. Extended hours are available on Tuesday evenings until 7.30pm.

When the practice is closed calls are answered by the out-of-hours service which is accessed via the surgery telephone number or by calling the NHS 111 service.

Dr Karen Wagstaff, the new provider, took over the practice on 1 December 2016. We previously inspected Church View Surgery on 27 January 2015 under the previous provider and the practice was rated good overall and for all domains and population groups. As the provider of the service changed on 1 December 2016 a new comprehensive inspection is required.

Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dr Karen Wagstaff is registered to provide treatment of disease, disorder or injury, surgical procedures, diagnostic and screen procedures and maternity and midwifery services. During our inspection we were told the practice had previously offered family planning services and would register for this prior to any further services being offered to patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

The inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 June 2017. During our visit we:

- Spoke with a range of staff (GPs, practice nurse, emergency care practitioner, practice manager and administrative and reception staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the three documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out an analysis of the significant events. However, the policy or procedure relating to the incident was not always reviewed as part of the process.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following an incident where a patient taking a certain medicine was not called for an annual review, staff reviewed the patient recall system to ensure review dates were set. Staff were individually updated about the change in the procedure by the practice manager.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns

about a patient's welfare. There was a lead member of staff for safeguarding. Staff told us the GPs would attend safeguarding meetings when possible or provided reports where necessary for other agencies.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and adults relevant to their role. GPs were trained to child safeguarding level three and the practice nurse to level two.
- A notice in the waiting room and on treatment room doors advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We received feedback a patient had not been offered a chaperone and we fed this back to the practice manager to investigate further. Following the inspection the provider informed CQC the chaperone procedure will be included within induction for all locum staff.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process

Are services safe?

to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. The practice nurses had qualified as an independent prescriber and could therefore prescribe medicines for clinical conditions within their expertise and another was in the process of completing their training. They received mentorship and support from the medical staff for this extended role. Staff were in the process of reviewing the Patient Group Directions, along with attendance at the appropriate training sessions, for use by the emergency care practitioner to allow them to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and fire drills were carried out by the landlord's representative. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. Further fire update training had been arranged for those staff who had not attended an update within the last 12 months.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and emergency equipment was available in the treatment room. The emergency equipment had been reviewed to include items the emergency care practitioner, as a registered paramedic, could use. We saw how staff effectively responded to an emergency situation during our inspection.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- A record of action taken in response to updates was kept by the practice manager.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results from the previous provider, were 99.2% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 95% with 9.7% exception reporting which is comparable to the CCG and NHS England averages. The practice shared with us the outcomes for 2016/17 which were not yet in the public domain so could not be compared to other local practices and the national average. They achieved 97.8% with 8% exception reporting rate.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was 100% which was 3% above the CCG and 10% above the national average.
- Performance for mental health related indicators was 100% which was 3% above the CCG average and 7% above the national average.

There was evidence of quality improvement including clinical audit since the provider had taken over in December 2016. The GPs worked collaboratively with the community consultant to review all patients medicines who resided at the special needs college to ensure they were effective. There had been several clinical audits

commenced in the last six months, one of these was a completed audit where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example, recent action taken as a result included review of patients prescribed medicines that were not contained with the local prescribing formulary to review the effectiveness of the medicine they were taking and whether another would be more appropriate.

We reviewed an audit of minor surgical procedures which documented nine cases where skin tags, two lipomas, two sebaceous warts and one sebaceous cyst had been removed from patients' skin. We asked if these were routinely sent for histology testing and were told they none of the samples taken were. Guidance from NHS England Service Specification for Minor Surgery Direct Enhanced Services recommends 'All tissue removed by minor surgery should be sent routinely for histological examination unless there are exceptional reasons for not doing so. The reasons for not sending a specimen for histology should be documented in the patient's record.' We saw that the GP performing minor surgery had been appropriately trained and there were processes in place to send samples off for histology. The lead GP assured us this would be reviewed to ensure any future samples were sent for histology. Following the inspection the provider told us they had reviewed the samples taken and introduced a protocol to follow which included sending samples for histology. We will follow this up at our next inspection.

Information about patients' outcomes was used to make improvements such as reviewing patients on the end of life register and propose new guidelines to follow to ensure patients are reviewed regularly and referred to social and healthcare support agencies.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long term conditions.

Are services effective?

(for example, treatment is effective)

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. For example by access to on line resources and discussion with colleagues.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Medical and nursing students and healthcare assistants shadowed staff at the practice and the location was working towards becoming a clinical placement area.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients'

consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long term condition and those requiring advice on their diet, smoking and alcohol and drug cessation.
- Smoking cessation advice was available from a local support group on the premises once a week. Health visitors and school nursing staff were co-located in the building. There was also a community library run by volunteers and practice staff linked in with the volunteers to be kept informed of local community events, the details of which they could share with patients.
- A counsellor and a psychological well being worker held weekly clinics offering talking therapies to patients. Staff told us the service was popular with patients particularly to assist them to make healthy life choices.

Are services effective?

(for example, treatment is effective)

- Staff also referred patients to the social prescribing project in Doncaster. They had the option to prescribe non-medical support to patients. This included support for loneliness and social isolation, to provide information regarding housing issues or advice on debt.
- Patients with multiple long term conditions attended one appointment to review all of their conditions rather than attending for several appointments.
- Volunteers held a community group at the practice on Wednesday afternoons offering the opportunity for people to meet up and engage in regular activities. Staff told us it was very popular with patients and staff used this as an opportunity to catch up with patients and pass messages on. For example, to remind patients of medication reviews.

The practice's uptake for the cervical screening programme was 87%, which above the CCG average of 82% and the national average of 81%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates

for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 89% to 98% and five year olds from 84% to 96%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Most of the 30 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Six less positive comments related to the wait for appointments.

We spoke with five patients and they told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with nurses and lower for GPs. These scores relate to the time prior to the new provider taking over the practice. For example:

- 79% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 76% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 72% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.

- 99% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- All of the patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average and the national average of 97%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% national average of 91%.
- 93% of patients said they found the receptionists at the practice helpful compared with the CCG and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment from nurses. The results were slightly lower for GPs, and again the survey was taken under the previous provider. For example:

- 78% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 66% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 91% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.

Are services caring?

- 91% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The NHS e-Referral service, more commonly known as Choose and Book, was used with patients as appropriate. (This is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.)

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 139 patients as carers (3% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support and referred to other agencies.

Staff told us that if families had experienced bereavement, their usual GP contacted them and sent them a sympathy card. This call was either followed by meeting and/or by giving them advice on how to find a support service. The practice also sent cards to parents of new born babies advising them of the services available at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Tuesday evenings until 7.30pm for working patients who could not attend during normal opening hours. Appointments were available with GPs, practice nurse and the healthcare assistant during this time.
- There were longer appointments available for those patients who needed them.
- Home visits were available for patients who had clinical needs which resulted in difficulty attending the practice. An emergency care practitioner had recently been employed who would visit patients at home with urgent needs to provide access to timely care.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- All patients living with dementia registered at the practice were encouraged to complete the form which was designed to make sure that, if someone was reported missing, the police could access important information about that person as soon as possible. The form contained information about their medical status, mobility, access to transport, places of interest and daily routines. Once completed, copies were made

and then available for use if the person should ever be reported missing. The idea is that speedy access to information will help officers track missing people down quickly.

Access to the service

The practice was open between 8am to 6.30pm Monday to Friday. Appointments were available from 8.30am to 11.30am and then throughout the afternoon daily. Extended hours appointments were offered on Tuesday until 7.30pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

The most recent results from the national GP patient survey, under the previous provider, showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 68% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 74% of patients said they could get through easily to the practice by phone compared to the CCG average of 67% and the national average of 73%.
- 79% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 83% and the national average of 85%.
- 86% of patients said their last appointment was convenient compared with the CCG average of 93% and the national average of 92%.
- 64% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 35% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 61% and the national average of 68%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them though six comments on the CQC comment cards reported a long wait for a routine appointment.

Following feedback from patients the provider had reviewed and revised appointment availability. A new emergency care practitioner (ECP) and advanced nurse

Are services responsive to people's needs?

(for example, to feedback?)

practitioner (ANP) had recently been employed, who along with the GPs, triaged all patients requesting same day appointments. A face to face appointment was then offered if clinically indicated. Some of the reception staff had undertaken care navigation training to enhance their ability to connect patients directly with the most appropriate source of help. When patients contacted the practice the receptionist, through a series of structured questions, would determine what the patient need was. They were then able to refer to information about services offered within the practice, other NHS providers and the wider care and support sector. Where appropriate, they would direct the patient directly to these services. The practice website was currently being updated to reflect the recent changes.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The GP, ECP or ANP would telephone the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system as there was a notice in the reception area and leaflets to give to patients.

We looked at two complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, with openness and transparency when dealing with the complaint. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, the practice reviewed the process for reviewing patients with other care providers involved to ensure regular multidisciplinary meetings took place and communication shared across the team.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The current provider commenced responsibility for the practice on 1 December 2016 and held a caretaker contract for 12 months. Staff told us there was a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a clear strategy for the next six months which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, a GP was the lead for safeguarding and the practice nurse was the infection prevention and control lead.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. GPs and the practice manager met weekly and outcomes fed back to staff by email and in person. Two whole practice meetings had been held in the last six months which provided an opportunity for staff to learn about the performance of the practice and future developments. Further meetings were scheduled.
- A programme of continuous clinical and internal audit had recently been implemented and was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, for legionella and health and safety.
- We saw evidence from minutes of meetings a structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the lead GP demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the GPs were approachable and always took the time to listen to all members of staff. Two GPs were CCG locality leads and one took the lead for Dementia and the other long term conditions across Doncaster.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multidisciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- The provider planned to establish a schedule of regular team meetings for staff.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues with GPs and practice manager and felt confident and supported in doing so.
- Staff told us the practice had been through a period of change and said they felt respected, valued and supported, particularly by the lead GP and practice manager in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good 

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

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

The provider encouraged and valued feedback from patients and staff. It proactively sought feedback through:

- The NHS Friends and Family test, complaints and compliments received.
- Staff through one to one meetings, general discussions. They told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

- A member of staff had been identified to engage with patients and establish a new patient participation group. They were currently exploring the use of social media to facilitate this and keep in touch with patients.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example reception staff were undertaking the care navigation training and the practice employed an emergency care practitioner to provide urgent care to patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The registered provider did not always follow nationally recognised guidance about delivering safe care and treatment and implement this as appropriate.</p> <p>In particular:</p> <p>Processes were not established for sending tissue removed by minor surgery for histological examination.</p> <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>