The Scott Practice

Quality Report

Greenfield Lane
Balby
Doncaster
DN4 0TG
Tel: 01302 850546
Website: www.thescottpractice.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Scott Practice on 14 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also rated as good for providing services for all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- 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.

We saw areas of outstanding practice:

Summary of findings

- Monthly multi-disciplinary meetings with a Geriatrician in attendance were held to review the care needs of older people and they offered rapid access appointments for those with complex needs.
- The practice provided excellent care to those patients with palliative care needs.

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

Importantly the provider should

- Take action to improve immunisation rates for children as figures were below national average for all standard childhood immunisations.
- Ensure that patient access to the practice by telephone is improved.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Care for patients with palliative care needs was outstanding.

Childhood immunisation rates were below average for the local area.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available on the website and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

There were some areas for improvement. We saw that information was available to help patients understand the complaints system on the web site but information about complaints was not displayed in the practice at either site.

We had a number of concerns raised by patients about the difficulty they had accessing the practice by telephone despite some attempts by the practice to improve systems.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care.

We found some aspects of the care to be outstanding.

The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with complex needs. Regular visits to local nursing homes were also undertaken.

Monthly multi-disciplinary meetings with a Geriatrician in attendance were held to review the care needs of older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. A community liaison nurse had been employed to support patients with complex needs.

Care for patients with palliative care needs was outstanding.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors.

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The practice had identified that they needed to develop women's health services and they had provided protected time for a GP to complete training relevant to this area.

Immunisation rates at the practice were below average for the local area for all standard childhood immunisations.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

We had a number of concerns raised by patients about the difficulty they had accessing the practice by telephone despite some attempts by the practice to improve systems.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability and for those who required translation services.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health received an annual physical health check and longer appointments were available. The practice

Summary of findings

regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out pre-screening and advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups. It had a system in place to follow up patients who had attended accident and emergency (A&E).

Summary of findings

What people who use the service say

We received five CQC comment cards and spoke with seven patients on the day of our visit. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

Patients told us they were satisfied with the service they received. The majority described the doctors and nurses as understanding and professional and the reception staff as helpful and polite.

The patients were complimentary about the care provided by the clinical staff. They told us the GPs listened to them, explained treatments to them and involved them in decisions about their care. For example patients described how their GPs gave them written information about their condition and explained the side effects of their medication. They said that their long term health conditions were monitored and they felt supported. One person described how well supported they were as a carer of a patient with a long term condition and they said they had been offered regular health checks.

Patients told us all the staff treated them with dignity and respect

Patients told us that they had difficulty getting through to the practice on the telephone but were complimentary about the availability of appointments. The majority said they could always get a same day appointment if required and they could also have telephone contact with a GP for advice. The patients said they could request to see a named GP although they may have to wait up to a week for an appointment. One patient was very complimentary about how the reception staff had managed their request for an urgent appointment for their child. They told us how the staff had ensured that the child was not at immediate risk and that they would be safe until the allotted appointment time.

Patients said that the practice was always clean and tidy and they told us that there had been improvements to the seating in the reception area.

We received information from the National Patient Survey. The information from the 2013 GP Patient Surveys showed 316 surveys were sent out and 121 patients responded. The results showed 92% rated their overall experience of this surgery as good, which was above the local CCG average of 84%.

Areas for improvement

Action the service SHOULD take to improve
Immunisation rates were below national average for all standard childhood immunisations.

We had a number of concerns raised by patients about the difficulty they had accessing the practice by telephone despite some attempts by the practice to improve systems.

Outstanding practice

The practice had excellent systems in place to support patients requiring palliative care.

Patients were identified on a palliative care register and alerts were placed on the electronic patient record. The practice had regular internal as well as monthly multidisciplinary palliative care meetings to discuss the care and support needs of these patients and their families. The meetings included among others, the practice designated lead GP for palliative care and an end of life care facilitator. We observed that the care needs of patients on the palliative care register were reviewed as were patients who may require palliative care in the future because of their diagnosis. Those patients on the register who had passed away were also reviewed to ensure best practice was promoted. We spoke to an external participant at the palliative care meeting. They spoke very positively about the practice approach to the

Summary of findings

way they reviewed their palliative care patients. They told us that their monthly meetings were more frequent than other practices locally and said they knew their patients well and took responsibility for their care.

Two named GPs, chosen by patients, were allocated to the care of the patient requiring palliative care. These patients were prioritised if they required an appointment and dedicated appointments were made available to them on the day requested. The named GPs met with the patient's families to review care needs and continued contact following bereavement. The GPs spoke to patients early in their diagnosis to enable them discuss the patient's wishes and develop their care plan. Pre-emptive medicines were prescribed to ensure that patients had access to appropriate treatment and pain relief as soon as required.

The lead GP had additional training in palliative care and had spent time working at a local hospice. Two GPs had also completed a certificate in palliative care.

The practice had employed a community liaison practitioner (CLP) jointly with a neighbouring practice. This member of staff supported patients in their end of life care. They said the GPs were very supportive to these patients and attended whenever they were required. We observed how positively this worked in practice during the inspection when the CLP, who was on a home visit, contacted a GP to discuss a patient who had deteriorated. The patients treatment was discussed and agreed and was commenced by the CLP, the GP also followed up with a home visit to the patient.

We were told that the practice was piloting the Electronic Palliative Care Co-ordination Systems (EPaCCS). This system enabled the practice to improve the way information about key details of patients care at the end of life was shared with relevant partners such as, district nurses and out of hour's services.

Monthly multi-disciplinary meetings with a Geriatrician in attendance were held to review the care needs of older people and they offered rapid access appointments for older people with complex needs.

The Scott Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, a GP and a practice manager specialist advisor.

Background to The Scott Practice

The Scott Practice is situated within a purpose built health centre in Balby near Doncaster. The practice also provides services at a branch site at The Scott Practice Village Surgery, Main Street, Sprotbrough, Doncaster, DN5 7RH. We visited this branch site as part of this inspection.

The practice provides General Medical Services (GMS) for 13576 patients under a contract with NHS England, Doncaster.

The clinical staff team work across both sites. There are ten GP partners, six male and four female, and a managing partner/practice manager. The practice has six nurses, two of whom are Advanced Nurse Practitioners (one of these works as the Community Liaison Practitioner), three of the other nurses are prescribers. There are also three health care assistants. An experienced team of 21 administrative and reception staff support the practice at both sites.

The reception opening hours at the Balby site are 7.30 am to 7 pm on Monday and Thursday, 8 am to 7 pm Tuesday, 7.30 am to 12pm and 2pm to 7pm Wednesday and Friday 8am to 6 pm. The Sprotborough site is open Monday to Friday 8 am to 12.30 pm. The practice is closed two Wednesday afternoons per month for staff training. The dates of these sessions are publicised in the surgery.

Patients can access the appointment system by telephone, presenting at reception or on line via the practice web site. Some appointments are pre-bookable and some are allocated to be booked on the same day.

Doncaster Clinical Commissioning Group (CCG) is responsible for out of hour's services. Calls to the practice are automatically redirected to this service outside of the practice opening hours.

The Scott Practice is a training practice for both medical and nursing undergraduates from local Universities and Kings College London.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the NHS Doncaster CCG, to share what they knew.

We carried out an announced visit on 14 January 2015. During our visit we spoke with a range of staff including four GPs, practice nurse manager, community liaison nurse, a practice nurse, administration manager, reception team leader, a student nurse, a health care assistant and the practice manager. We also spoke with seven patients who used the practice.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed five CQC comment cards where patients and members of the public had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included, reported incidents, national patient safety alerts, clinical audits and comments and complaints received from patients. The practice had a written procedure which clearly identified the action staff were required to take in the event of an incident. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw records which showed the practice had managed incidents consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice also had a designated lead GP in this area. Significant events analysis was a standing item on the weekly and monthly practice meeting agenda. There was evidence that the practice had learned from these events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise issues for discussion at the practice meetings.

The practice manager showed us the system they used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Records of action taken were also maintained. We saw that where there had been a failure in the procedures for referring a patient to secondary care (hospital) the procedures had been reviewed and changed to ensure that the risk of reoccurrence was minimised.

Where patients had been affected by something that had gone wrong we saw that, where applicable, action had been taken to protect patient's health and welfare.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all the staff had received training on safeguarding both adults and children. Record's showed training was provided at a level commensurate with their role. Staff we spoke with were aware of their responsibilities and knew how to share information. Contact details of relevant agencies were available and easily accessible for all staff.

The practice had a designated lead GP in safeguarding vulnerable adults and children. They confirmed they had completed training in safeguarding children at the appropriate level for this role.

Staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern. The practice held a monthly safeguarding meeting with representatives from relevant persons from outside agencies such as the health visitor. We attended a meeting and observed that this was led by the GP with the safeguarding lead role. GP's had provided information for the meeting where there were any concerns about children registered at the practice. Children's attendance at out of hour's services and accident and emergency departments were reviewed and non-attendance for routine appointments was also reviewed. The meetings were recorded and any ongoing actions were agreed. Where a child was identified as at possible risk this was recorded as an alert on the patient's electronic records. We observed that the lead GP was proactive in cross referencing information of concern to other records as appropriate and ensuring any ongoing action was agreed with partner agencies.

A system was also in place to highlight vulnerable adult patients on the practice's electronic patient record which included information to make staff aware of any relevant issues when the patient attended an appointment. Vulnerable adults who may be at risk were reviewed at the practice multi-disciplinary meeting.

Information was provided to patients on the web site and in the practice about how to recognise possible signs of abuse for both children and adults and where to refer any concerns they may have. They also provided information about reporting concerns relating to domestic abuse.

There was a chaperone policy in place and information for patients was displayed in the practice and on the website. The nursing staff and health care assistants usually acted

as chaperones when necessary. However reception staff had also received training and had the appropriate recruitment checks to enable them to undertake this role if required.

Medicines management

Medicines were kept in a secure storage area, which could only be accessed by clinical staff. We saw that dedicated fridges were used to store medicines requiring refrigeration. We saw that these were not hardwired to minimise the risk of the fridges being accidently turned off however the plugs had been labelled. Logs of the daily checks of the temperature of fridges had been maintained which showed these were within the recommended temperature ranges for the medicines stored. A protocol was readily available to staff to advise on the action to take in the event of the fridge temperatures being outside of these recommended ranges.

We saw that medicines for use in emergencies were accessible to staff. We saw these medicines were in date and were routinely checked.

Requests for repeat prescriptions were taken by e-mail, online, post, via the local pharmacy or at the reception desk. Repeat prescriptions were signed by a GP and checks were made to ensure the correct person was given the prescription. There were procedures in place for GP reviews to monitor patients on long term medicine therapy.

We saw information relating to prescribing data for the practice. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice which identified prescribing at the practice were within expected levels. Any changes in guidance about medicines were communicated to clinical staff by the practice manager and a log of actions taken was maintained. Where advice about one medicine had changed a GP had completed an audit of patients prescribed the medicine and identified those patients whose medicine required changing. A further audit was completed and they had found that whilst the practice had not completely met the standards there was improvement.

Cleanliness and infection control

We observed the premises at both sites to be clean and tidy. We saw there were cleaning schedules in place and the cleaning company employed by the practice had competed regular audits of the cleaning standards. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a designated lead nurse for infection control. The training log showed that all the staff had received infection control training and staff we spoke with were aware of the procedures in place to minimise the risks of cross infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Hand washing sinks, antibacterial hand gel and hand towel dispensers were available in treatment rooms and hand gel was available for patients in the reception area.

The practice had a process for the management and testing of legionella (a bacterium found in the environment which can contaminate water systems in buildings). They also had systems in place for servicing air conditioning units in the practice on a regular basis.

An infection, prevention and control audit had been completed in August 2014 and an action plan had been produced. As part of the action plan all the reception area seating had been replaced.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly.

Staff we spoke with were aware of how to access equipment in an emergency and we observed that emergency equipment was easily accessible to staff. The equipment was checked weekly to ensure it remained in working order.

We saw that systems were in place for portable appliance test (PAT) and calibration of equipment and that the tests were up to date.

Equipment used for minor surgical procedures was for single use only and the equipment we checked was within its expiry date.

Staffing and recruitment

The practice had a recruitment policy and procedure. This document identified the checks that were required for recruitment of clinical and non-clinical staff and the

Good

Are services safe?

process to be followed to obtain these checks. For example, it included the type of proof of identification required, number of references, checking registration with the appropriate professional body or criteria for criminal records checks through the Disclosure and Barring Service (DBS). We saw relevant checks had been completed in the staff files we reviewed

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. A GP described how they ensured that there was sufficient cover to provide appointments for patients and the processes in place to manager annual leave.

Staff told us there was usually enough staff to maintain the smooth running of the practice. The practice took into account longer term succession planning for GP partners and the nurses and as vacancies arose they considered the team and skills required prior to recruitment. The practice manager told us that they also considered the staff team and skills required during appraisals and in their review of significant events.

We received positive comments about the staff and patients told us they found all the staff to be caring and helpful. Patients also told us that they could usually get an appointment the same day if required. We did receive some comments about how difficult it could be to get through to the practice by telephone. The practice had recognised this through their surveys and provided additional staffing but this had not made sufficient impact and situation was being reviewed.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice.

Risks were assessed and rated and actions to reduce and manage the risk were recorded. For example, we saw that health and safety and fire risk assessments had been completed and action plans were in place to ensure any shortfalls were addressed. Staff had completed health and safety and fire safety training.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. We saw emergency equipment was accessible to staff including access to oxygen and an automated external defibrillator.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use.

During the inspection the emergency alert system was activated in the practice. We observed that when the computer system panic button was activated a message was sent to all staff and the staff reacted appropriately to the call.

A detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This included contact numbers for services such as water, gas and electricity and included guidance for staff in the event of a major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed at the practice meetings. We were told that the practice monitored changes in best practice guidelines and developed new protocols as required to ensure that best practice was implemented in a timely manner.

We found from our discussions with the GPs and nurses that staff completed assessments of patients' in line with NICE guidelines. We were informed that the practice provided care for patients in line with best practice guidelines which may, in some areas, be above that required as a minimum standard by Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. For example, they told us that monitoring patients with cardoivascular disease and chronic kidney disease was in line with NICE guidance, and this was above the minimum QOF standards. this assisted them to identify any changes in pateints health care needs at an earlier stage. Care review meetings for palliative care patients were completed monthly rather than three monthly as required by minimum standards.

We were told that the GPs were encouraged to develop individual areas of interest in specialist clinical areas such as diabetes, heart disease and dermatology. The practice nurses supported this work through specific clinics in line with their own knowledge and skills which allowed the practice to focus on specific conditions.

Clinical staff we spoke with told us they were well supported and said they shared information and felt able to ask colleagues for advice and support. They told us that they utilised their colleague's expertise when considering care and treatment options for patients. For example, we were told two of the practice GPs had previously worked as paediatricians and the other GPs would, if required, liaise with them or refer their patients to them when considering the health care needs of children.

The data from the local Clinical Commission Group (CCG) relating to the practice's performance for antibiotic prescribing was comparable to similar practices.

The GPs we spoke with used national standards for the referral of patients with suspected cancers to be referred and seen within two weeks. Administration staff were able to describe the process for ensuring patients were referred in a timely manner and how they followed up patients who did not attend for appointments following an urgent referral. They also described how this process had been improved where problems had been identified.

Interviews with GPs showed that the culture in the practice was that patients clinical need was the basis of all treatment and access decisions.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service. For example, data was used to identify where changes were required in prescribing practice as NICE guidance had changed.

The GPs told us their clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). We saw a list of the audits undertaken which included a number of medication audits and looked at two of these in detail. These showed that prescribing practice had improved over time.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease).

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had

been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had excellent systems in place to support patients requiring palliative care. Patients were identified on a palliative care register and alerts were placed on the electronic patient record. The practice had regular internal as well as monthly multidisciplinary palliative care meetings to discuss the care and support needs of patients and their families. We attended a palliative care meeting as part of the inspection. The meeting included the practice designated lead GP for palliative care and an end of life care facilitator. We observed that the care needs of patients on the palliative care register were reviewed as were patients who may require palliative care in the future because of their diagnosis.

We saw that two named GPs were allocated to the care of the patient requiring palliative care. We were told the patients chose their named GPs. These patients were prioritised if they required an appointment and dedicated appointments were made available to them. We were told the named GPs met with the patient's families to review care needs and continued contact following bereavement. The GPs told us they speak with patients early in their diagnosis to enable them to discuss the patient's wishes and develop their care plan. Pre-emptive medicines were prescribed to ensure that patients receiving end of life care had prompt access to appropriate treatment and pain relief.

The practice had employed a community liaison practitioner (CLP) jointly with a neighbouring practice. This member of staff told us how they supported patients in their end of life care. They said they worked closely with the GPs. They told us the GPs were very supportive to these patients and attended whenever they were required. We observed how positively this worked in practice during the inspection when the CLP, who was on a home visit, contacted a GP to discuss a patient who had deteriorated and required intervention to manage their symptoms. Treatment was agreed and implemented by the CLP and the GP conducted a follow up home visit.

We spoke to an external participant at the palliative care meeting. They spoke very positively about the practice approach to the way they reviewed their palliative care patients. They told us that the monthly meetings were more frequent than other practices locally and they said the GPs knew their patients well and took responsibility for their care.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with essential training courses such as annual basic life support, fire safety and safeguarding adults and children.

GPs were up to date with their yearly continuing professional development requirements and two GPs had recently been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years).

All staff undertook annual appraisals that identified learning needs from which action plans were documented.

Training was provided for GPs to improve care provision and extend the services available for patients. For example, a GP told us the practice had identified that they needed to develop women's health services. They said that they had protected time to complete training relevant to this area such as fitting intrauterine devices (sometimes called a coil), contraceptive implants and endometrial biopsy. They told us that the training had also included visiting gynaecology clinics. The lead GP told us they had additional training in palliative care and had spent time working at a local hospice. We were told two GPs had also completed a certificate in palliative care.

Practice nurses and health care assistants were expected to perform defined duties and they were trained to fulfil these duties. A new member of staff said they had their training needs assessed and training had been arranged with the first week of employment. Training for this group of staff was also targeted towards improving and expanding services for patients. For example, the practice had improved care for patients following minor surgery and utilised surgery time by training health care assistants to remove sutures. They had also trained health care assistants to recognise health conditions which may require intervention, such as an irregular heartbeat.

Good

Are services effective?

(for example, treatment is effective)

Clinical staff told us they were well supported and said there were plenty of opportunities for clinical support and training. They told us that dedicated time was given daily for informal meetings and discussion.

Non-clinical staff also told us they were well supported and had access to training relevant to their role and for career development. For example, one person told us they had received training in performance management, employment law and finance. Staff told us they were well supported and that the practice manager was always available for advice and support.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. We attended the three multidisciplinary meetings being held during the inspection. We observed patients care needs including children at risk, vulnerable adults, those with complex needs and those requiring palliative care were reviewed during the meetings. We saw that a wide range of health professionals were invited and attended the meetings including a consultant geriatrician, district nurse and health visitor. We received positive feedback from the participants we spoke with about how the practice worked with them and shared information.

The practice had systems in place to monitor if patients attended appointments where they have been referred by the practice to secondary care services such as the hospital. Where the practice was informed the patients had been discharged by the hospital without being seen, possibly due to non-attendance, the GP would review the referral and discuss this with the patient.

Procedures were in place to manage information from other services such as the hospital or out of hour's services. Staff were aware of their responsibilities when processing discharge letters and test results and there were systems for these to be reviewed and acted upon where necessary by clinical staff.

Information sharing

The patient record system used in the practice and that used by the partner agencies, such as district nurses, were separate systems. To ensure that information about patients' needs was shared, where required, regular multidisciplinary meetings were held in the practice. We observed that the practice provided information about patients on the palliative care register and who were in the terminal phase of their illness to the out of hours services. We were told that the practice was piloting the Electronic Palliative Care Co-ordination Systems (EPaCCS) to improve information sharing. This system enables the recording and sharing of people's care preferences and key details about their care at the end of life with relevant partners such as district nurses and out of hour's services.

Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care.

Consent to care and treatment

We found that GPs were aware of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and we saw from the training log that training in this area was provided. The clinical staff we spoke with understood the key parts of the legislation.

We saw examples in clinical records where consent for treatment had been discussed and we saw copies of consent forms which recorded what had been discussed. The consent forms had been updated to include more information although we saw the previous forms also included relevant information.

Clinical staff we spoke with demonstrated a clear understanding of the assessment procedures to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. We observed records where competency assessments had been completed for patients under the age of 16 years which gave a clear rationale for the decisions made.

Health promotion and prevention

The practice offered NHS Health Checks and was involved with local CCG bowel cancer screening programme. Patients were invited for their health checks annually based on their birth date. Medicine reviews and long-term conditions were reviewed at the same appointment to avoid multiple visits for the patient.

Good

Are services effective?

(for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability, chronic disease or mental health problem and these patients were offered an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data showed that the practice performance for childhood immunisations was below average compared to figures for the local CCG. The practice recognised this and was aware of issues relating to their practice population which impacted on the uptake of immunisation programmes.

The practice web site provided access to patient information and links other websites such as NHS Patient Information websites. The information on the website could be instantly translated in other languages via translation programme. A range of health information leaflets were also displayed in the practice waiting area.

The majority of patients we spoke with were very complimentary about the level of information they received about their treatments and possible side effects of medicines during consultations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey where from 316 surveys 121 responses were received. Data from the national patient survey showed 92% of patients rated the practice as good or very good which was above average for the local CCG. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 95% of practice respondents saying the GPs and nurses were good at listening to them and 95% said the GPs gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received five completed cards which were positive about their experience of the service. We also spoke with seven patients on the day of our inspection. The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We also saw 22 completed Patient Participation Group (PPG) survey questionnaires. These had been completed in the three months from November 2014 and were all very positive about the care received. Patients had complimented the practice on the GPs caring altitude, the level of care and support they had received following bereavement and on the explanation of treatments and procedures.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard at the main site was located away from the reception desk which helped keep patient information private. At the branch site we observed that the reception staff did not make use of a glass partition at the reception desk when speaking on the telephone and conversations could be overheard in the reception area. Records showed that staff had received training in patient confidentiality.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the national patient survey showed 93% of practice respondents said the GP involved them in care decisions, 88% felt the GP was good at explaining treatment and results and 97% of patients said they confidence and trust in their GP. These results were above average compared to others in the CCG area.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. The majority of patients we spoke with and all those who responded on the CQC comment cards told us they felt listened to and supported by staff. They said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

We saw care plans had been produced for patients who included those with long term conditions such as asthma and for those who had complex needs or those patients at high risk of admission to hospital. We saw that a care plan for one of these patients also included the needs of their main carer.

Staff told us that translation services were available for patients who did not have English as a first language and longer appointments would be booked when patients required this service.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required. One patient spoke very

Good

Are services caring?

positively about the support they had received as a carer for a patient with a long term condition. They told us they had been signposted to other support services and had been offered regular health checks by their GP.

Notices in the patient waiting rooms and patient website informed patients how to access a number of support groups and organisations. For example, written information was available for carers to ensure they understood the various avenues of support available to them.

Where patients required palliative care named GPs involved the patient's families in care planning and they continued contact with families following bereavement. The GPs told us they speak to patients early in their diagnosis to enable them discuss the patient's wishes and to plan care and treatment accordingly.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us that they engaged regularly with the local Clinical Commissioning Group (CCG) and the Local Medical committee (LMC) and some of the GPs were board members of the CCG and LMC. The GPs and the practice manager attended CCG and LMC meetings to discuss local needs and service improvements that needed to be prioritised. We saw from records that the practice provided information to the CCG about issues which affected their patients. For example, the practice had reported an issue with appointments provided by a secondary care provider resulting in a patient being inappropriately discharged.

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. Patients could choose double appointment if they wanted and notices to this effect were displayed in reception. The GPs told us that if patient indicated they were depressed when they rang for an appointment they were routinely offered a double appointment. They said that if patients needed to use a translation service or had learning disabilities they were also booked a double appointment to allow adequate time for discussion.

A receptionist told us how they supported one patient with dementia to access the practice after they had identified they were missing appointments. They told us they now contacted the patient to remind them about their appointment and this had reduced their missed appointments. A GP told us how they supported a member of staff who had a hearing impairment by adding additional safety features to the fire alarm system to meet their needs.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG had undertaken a number of surveys to understand how patients contacted the surgery and the reasons why patients were not using the online booking systems. The practice had put systems in place to promote the registration for the online systems to ease the pressures on the incoming telephone lines. They had also looked at patient's experience of referral to secondary care and found that the majority of patients had not had their preferences discussed with them by GPs or reception staff. Staff had been prompted to ensure that patient's choice was promoted when booking hospital appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had systems in place which alerted staff to patients with specific needs who may require a longer appointment or additional assistance while attending the practice. For example, the practice had system of adding alerts to records for patients who needed assistance to get from the waiting room and alerts for patients who had a hearing or visual impairment.

The main site was situated within a building which was purpose built and was suitable to meet the needs of people with disabilities. The patient areas were over two floors with lift access available, the doors into the building opened electronically and the patient areas were sufficiently spacious for a wheelchair user. The patient areas at the branch site were on the ground floor and had wheelchair access.

We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

Access to the service

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. This indicated the patients were generally satisfied with the appointments system at the practice although there were areas for improvement. For example, 71% of respondents described their experience of making an appointment as good. However only 54% of respondents said they found it easy to get through to the surgery by phone, the local CCG average was **71%**.

The practice had identified that accessing the practice by telephone required improvement and had looked at the issues relating to this. In response to their findings they had provided additional reception staff and were promoting their online services with the assistance of the PPG.

Patients we spoke with told us that they had experienced problems getting through to the practice by telephone.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients who were working told us this had created problems trying to book appointments before work or during working hours due to the length of time it took to get through. Patients told us once they were able to speak to a receptionist they could get an appointment for urgent care on the same day. They also told us they could usually get an appointment with the GP of their choice although they may have to wait up to a week sometimes for an appointment to see a specific GP. Patients said that they could also request advice and a GP would contact them, they said that they found this helpful.

Reception staff told us some appointments were pre-bookable and some had been allocated for booking on the same day. A protocol was in place to guide staff when booking appointments. Staff said same day appointments were always made available for those requiring palliative care and for children under the age of one year. A triage nurse was on call each day to see or advise patients requesting urgent appointments. Extended hours appointments were available and these included appointments early morning and late evening.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Home visits were made to local care homes as required and to those patients who needed one.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were 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 on the web site but the information was not displayed in the practice at either site. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. The practice had displayed "Your opinion counts" surveys in the reception area to enable patients to comment on the service they received. We saw a number of these had been completed and all included very positive comments about the service.

We looked at complaints received in the last 12 months. We saw that 23 complaints had been received. The records showed that complaints had been dealt with in a timely way and patients had received a response which detailed the outcomes of the investigations, an apology where required and information on how to escalate their complaint.

We saw that learning from complaints was shared with staff although audits of the complaints to identify patterns and trends had not been formally undertaken. For example, the practice had received a complaint regarding a receptionists' attitude. Training had been provided to address these issues and the practice had invited a patient to give a presentation to staff on "Perception" to improve communication.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had developed a mission statement in consultation with their staff. The mission statement included aims to provide a comprehensive range of consistent, high quality, safe primary care services which are patient centred, including effective drug therapy and access to secondary care services within a reasonable time frame. To educate patients and stimulate awareness of their health needs and to promote a stimulating, supportive learning environment for all.

Our discussions with staff and patients indicated that these visons and values were embedded within the culture of the practice. Staff told us that the practice was patient focused and they told us the staff group were well supported.

Governance arrangements

We found there was a well-established management structure with clear allocation of responsibilities and all the staff we spoke with understood their role. We found that the senior management team and staff looked to improve the service being offered. All the staff we spoke with felt that the practice delivered a high quality of service. Regular meetings were undertaken including regular partners, staff and multidisciplinary meetings.

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

The practice had a five year plan which had been developed in 2011. This included succession planning and an action plan had been developed to replace two GPs who were looking to retire. Planned IT changes had also been implemented.

The practice had a number of policies and procedures in place to govern activity and these were available to staff. A staff survey had been completed to assess staff understanding of the policies and procedures in place.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which were used to monitor quality and systems to identify where action should be taken. For example, the GPs s clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. One of the completed audits we saw related to advice about a medicine which had changed. A GP had completed an audit of patients prescribed the medicine and identified those patients whose medicine required changing. A further audit was completed and they had found that whilst the practice had not completely met the standards there was improvement.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out and where risks were identified action plans had been produced and implemented. For example, we saw that fire and health and safety risk assessments had been completed and were reviewed annually. We saw from records staff had received fire safety and health and safety training.

Leadership, openness and transparency

The staff told us that there was a relaxed atmosphere in the practice and there were opportunities for staff to meet through the day for discussion or to seek support and advice from colleagues.

The practice held regular practice meetings. We looked at the minutes from the last two meetings and found that performance, quality and risks had been discussed.

We saw from minutes that team meetings were held regularly, at least monthly and clinical meetings were held every week. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. All the patient feedback we reviewed was positive.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG) which had steadily increased in size. The core group comprised of 13 members with a further 31 members following in a virtual group on a social media site. The social media site had been established by one of the patients on the group.

The PPG included representatives from various population groups with patients in the older age groups making up the core group and younger patients being more active via social media. One of the PPG members had also joined the wider Doncaster area group.

The PPG had been involved in planning the annual surveys, reviewing the feedback and agreeing the action plan. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys and the quarterly newsletter were available on the practice website.

The practice manager told us they had identified that recent changes in partners and nursing staff had impacted on staff morale. The practice had gathered feedback from staff through staff meetings and a staff survey. They told us they had implemented a number of initiatives to raise staff morale including a wage review, rewards for performance and staff treats such as gifts and a Christmas party. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was a GP training practice. The practice trained junior doctors who are on the Doncaster Vocational Training Scheme. This is a three-year course which doctors can embark on after two years in (Foundation) hospital jobs. It constitutes 18 months in General Practice and 18 months in hospital specialities like paediatrics, psychiatry, obstetrics and gynaecology.

The practice had completed reviews of significant events and other incidents and shared the information with staff at meetings to ensure the practice improved outcomes for patients. For example, we saw evidence where one incident had led to a further audit of referrals to secondary care such as the hospital. As a result when patients had been referred to secondary services they were monitored to ensure they had been seen or had further management.