Drs Phillips, Harding and Eggitt

Quality Report

The Oakwood Surgery
Masham Road
Cantley
Doncaster
South Yorkshire
DN4 6BU
Tel: 01302 537611
Website: www.theoakwoodsurgery.nhs.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 inspection visit on 13 January 2015 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence the practice was safe, effective, caring, responsive and well led. It was also rated as good for providing services for all population groups.

Our key findings 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.
- 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 staff were caring and respectful; they were involved in their care and decisions about their treatment.
- The service was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- Patients said they found it easy to make an appointment, with urgent appointments available the same day.
- 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 including:

- The practice team had been trained in customer services to try to ensure a positive service for their patients.
- A member of staff has been trained by the practice to acts as their patients' advocate. Patients discharged from hospital were contacted by this person. This personal contact helped to ensure any actions required were implemented immediately. In addition

Summary of findings

patients who needed support from other services were given the contact details. The advocate also had a role in trying to prevent hospital admission by proactively contacting patients at high risk of admission.

- Within the waiting area the practice had a clinical information booklet. This was for patients who wished to learn more about health.
- The practice was using Skype and emails to communicate with their patients. This helped to offer the patient other ways of accessing their GP and kept them up to date with information relating to the practice. One of the GPs was also using Twitter and Facebook for educational purposes.
- The practice had a dedicated emergency telephone number, for patients to access the service in the event of an emergency.

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 safe. There were standard operating policies and local procedures in place to help ensure any risks to patient's health and wellbeing was minimised and managed appropriately. The practice learned from incidents and took action to prevent a recurrence. Medicines were stored and managed safely. The practice building was clean and well maintained and systems were in place to oversee the safety of the building.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' received care and treatment in line with recognised best practice guidelines such as the National Institute for Health and Care Excellence. Their needs were consistently met and referrals to secondary care were made in a timely manner. The practice worked collaboratively with other agencies to improve the service for patients.

Are services caring?

Good

The practice is rated as good for caring. The patients who responded to Care Quality Commission (CQC) comment cards and those we spoke with during our inspection, gave positive feedback about the practice. Patients described to us how they were included in all care and treatment decisions and they were complimentary about the care and support they received.

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. It engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services, where these were identified. The practice was responsive when meeting patients' health needs. There were procedures in place which helped staff respond to and learn lessons when things did not go as well as expected. There was a complaints policy available in the practice and staff knew the procedure to follow should someone want to complain.

Are services well-led?

Good

The practice is rated as good for being well-led. 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 meetings. Patients and staff felt valued and a proactive approach was taken to involve and seek feedback from patients and staff.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice made provision to help ensure care for older patients was safe, caring, responsive and effective. All patients over 75 years had a named GP. There were systems in place for older patients to receive regular health checks, and timely referrals were made to secondary (hospital) care. Good information was available to carers.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. There were systems in place to ensure patients with multiple conditions received one annual recall appointment wherever possible. This helped to offer the patient a better overall experience in meeting their needs. Healthcare professionals were skilled in specialist areas and their on-going education meant they were able to ensure best practice was being followed.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young patients. They helped to ensure care for these patients was safe, caring, responsive and effective. The practice provided family planning clinics, childhood immunisations and maternity services. There was health education information relating to these areas in the practice to keep people informed.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age patients including those recently retired. They helped to ensure care for these patients was safe, caring, responsive and effective. The practice had extended hours to facilitate attendance for patients who could not attend appointments during normal surgery hours. There was an online booking system for appointments, as well as a full range of health promotion and screening which reflects the needs for this population group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. They helped to

Summary of findings

ensure care for these patients was safe, caring, responsive and effective. The practice had arrangements in place for longer appointments to be made available where patients required this and access to translation services when needed.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice helped to ensure care for these patients was safe, caring, responsive and effective. The patients had annual health checks; they had access to professional support such as the local mental health team and psychiatric support as appropriate.

Summary of findings

What people who use the service say

We received 35 CQC comment cards where patients shared their views and experiences of the service. We also spoke with two patients on the day of our inspection; one who was a member of the patient participation group (PPG).

Patient and comments from the CQC comment cards were positive about how the practice worked and met their needs. They told us, the staff were helpful, caring, friendly, efficient, and treated them with dignity and respect. They felt all staff communicated with them well and felt supported in making decisions about their care. With the exception of one patient who had experienced a problem in booking an appointment to see the doctor, other patients reported the service was good. They were able to get an appointment the same day when needed, and they would recommend the practice to other patients.

Outstanding practice

- The practice team had been trained in customer services to try to ensure a positive service for their patients.
- A member of staff has been trained by the practice to acts as their patients' advocate. Patients discharged from hospital were contacted by this person. This personal contact helped to ensure any actions required were implemented immediately. In addition patients who needed support from other services were given the contact details. The advocate also had a role in trying to prevent hospital admission by proactively contacting patients at high risk of admission.
- Within the waiting area the practice had a clinical information booklet. This was for patients who wished to learn more about health.
- The practice was using Skype and emails to communicate with their patients. This helped to offer the patient other ways of accessing their GP and kept them up to date with information relating to the practice. One of the GPs was also using Twitter and Facebook for educational purposes.
- The practice had a dedicated emergency telephone number, for patients to access the service in the event of an emergency.

Drs Phillips, Harding and Eggitt

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector and a GP.

Background to Drs Phillips, Harding and Eggitt

The practice has three general practitioner (GP) partners, (two female and one male). Working alongside the GPs are three female practice nurses and two female health care assistants. There is an experienced management team including, a practice manager and assistant manager, and administration/reception staff.

This is a training practice for Foundation Year 2 doctors and for trainee GPs.

The practice has a General Medical Services (GMS) contract. A GMS contract is the contract between general practices and NHS England for delivering primary care services.Their registered list of patients is 5,315.

The practice has a doctor triage system, where the reception staff take a note of the patients name and telephone number and arrange for one of the doctors to call them back. The doctor directs the patient to the most appropriate person who is able to deal with the patients' problem. This may include an appointment with a doctor or nurse.

Opening times are Monday, Tuesday, Thursday and Friday 8.30am – 1pm and 1.30pm – 6pm, Wednesday 7.30am – 1pm and 1.30pm to 7.45pm. Extended opening hours are Wednesday 7.30am – 8am and 6.30pm to 7.45pm.

The practice also had a dedicated emergency telephone number, so patients were able to access staff when needed in an emergency situation.

When the practice is closed calls are diverted to the Doncaster Out of Hours service.

A wide range of practice nurse led clinics are available at the practice and these include: vaccinations and immunisations, cervical smears, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease.

Why we carried out this inspection

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. 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.

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.

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, such as NHS England local area team and Doncaster Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced inspection visit on 13 January 2015. During our inspection we spoke with staff including two GPs, a (FY 2) doctor who was in their second year, post qualification and had been at the practice four months, the practice manager, deputy practice manager, a nurse and two reception staff.

We spoke with two patients visiting the practice, one of whom was a member of the patient participation group (PPG). We observed how patients were being spoken with on the telephone and within the reception area. We also reviewed 35 CQC comment cards where patients had shared their views and experiences of the practice.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Good

Are services safe?

Our findings

Safe track record:
The practice had systems in place to record, monitor and learn from incidents which had occurred within the practice. Safety was monitored using information from a range of sources. These included the Quality and Outcomes Framework (QOF), patient survey results, patient feedback forms, the Patient Participation Group (PPG), clinical audit, appraisals, professional development planning, education and training.

Staff we spoke with 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. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents:
The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was a record of eight significant events that had occurred during the last year and we were able to review these. We were told by the practice manager and noted meetings were held following incidents with a focus on openness, transparency and learning when things went wrong. Action plans were reviewed to ensure actions from past significant events and complaints had been carried out. There was evidence the practice had learned from these and the findings were shared with staff. For example, there had been an incident where the vaccines refrigerator had been left open. Records showed staff had reported the incident and followed the practice protocol; the vaccine manufacturer had been contacted and appropriate action had been taken. The practice manager notified staff of the incident and the actions taken via email. Staff were able to give examples of the processes used to report, record and learn from incidents.

Reliable safety systems and processes including safeguarding:
There were policies and protocols for safeguarding vulnerable adults and children. Staff had received training relevant to their role and this included safeguarding vulnerable adults and children training. We asked members of medical, nursing and administrative staff about their most recent training. They knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities, how to contact the relevant agencies and contact details were easily accessible.

There was a system to highlight vulnerable patients on the practice's computer records system. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. This was to ensure risks to children and young people, who were looked after or on child protection plans, were clearly flagged and reviewed. The safeguarding lead GP was aware of the vulnerable children and adults on the practice patient list. Records demonstrated there was frequent liaison with partner agencies such as, health visitors and social services.

In the practice waiting room we saw information referring to the use of a chaperone during consultations and examinations. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Staff told us when the GP who is on triage duty arranged an appointment for a patient, where appropriate, they asked if they would like to have a chaperone present. Staff told us when chaperones were needed the role was carried out by the clinical staff.

Medicines management:
A representative from the Doncaster CCG Medicines Team supported the practice and gave advice on safe, effective prescribing of medication. This included the checking and advising on medicines that needed regular monitoring and reviewing, such as Warfarin. They also monitored and audited medicines to ensure the practice followed good practice guidance, published by the Royal Pharmaceutical society.

The GPs also monitored patient's medicines and this included those patients who were discharged from hospital. Patients told us reviews of their medication had taken place six to 12 monthly or more often depending on their individual needs.

We saw emergency equipment was available in the surgery which included emergency medicines. The practice had arrangements for managing medicines to keep patients safe. Correct procedures were followed for the prescribing, recording, dispensing and disposal of medicines. We saw

minutes of meetings where the practice staff had discussed their emergency protocols. This included the accessibility of emergency drugs, and the action of individual staff (for example, administrative staff) in an emergency situation. Information showed where risks had been identified, action had been taken and this information had been included when reporting significant events.

There were standard operating procedures (SOP) in place for the use of certain medicines, and they also had patient group directives (PGD). PGDs are specific written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, flu vaccines and holiday immunisations. PGDs ensure all clinical staff follow the same procedures and do so safely.

Vaccines were stored in a locked medicines refrigerator (and a sticker was in place reminding staff to lock the refrigerator). Staff told us the procedure was to check the refrigerator temperatures every day and ensure the vaccines were in date and stored at the correct temperature. We were shown their daily records of the temperature recordings and the desired refrigerator temperatures for storage were maintained.

Cleanliness and infection control:

We observed the premises to be clean and tidy. We saw there were cleaning schedules and audits took place and any actions from these had been addressed. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

The practice nurse together with the practice manager had lead roles in infection control. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. This included areas, such as hand washing and cleaning of equipment. There was a policy for needle stick injury; staff we spoke with confirmed their understanding. We were shown the body fluids spillage kits, which were easily accessible to staff.

Equipment:

We saw equipment was available to meet the needs of the practice and this included: a defibrillator and oxygen, which were readily available for use in a medical emergency. Routine checks had been carried out to ensure they were in working order.

We saw equipment had up to date annual, Portable Appliance Tests (PAT) completed. Systems were in place for routine servicing and calibration of medical equipment where required. The sample of portable electrical equipment we inspected had been tested and was in date.

Staffing and recruitment:

Records we looked at contained evidence of appropriate recruitment checks, prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We noted in minutes of practice meetings, where potential staff shortages had been identified, for example assistance with scanning, action had been taken to address the situation.

Monitoring safety and responding to risk:

The practice had clear lines of accountability for patient care and treatment. Each patient with a long term condition and those over 75 years of age had a named GP. The GPs, nurses and practice manager also had lead roles in areas such as, safeguarding, medicine management and infection control. Each lead had systems for keeping staff informed and up to date/using the latest guidance. For example, safety alerts were circulated to staff and relevant changes made to protocols and procedures within the practice. The practice manager and staff told us safety alerts were discussed at staff meetings where the information was reinforced. We also saw minutes of a team meeting dated September 2014, where staff had been

reminded to look in the practice policy folders to make sure their knowledge was up to date. The information reminded staff where the folders were located; in paper format in the practice and on the computer.

Areas of individual risk were identified. Information relating to safeguarding was displayed and staff had received relevant training.

Arrangements to deal with emergencies and major incidents:

There was a business continuity and management plan to help ensure the smooth running of the practice in the event of a major incident. These included the loss of electrical or telephone systems. Staff were aware of the protocols should an incident occur and this included emergency contact numbers. We also saw minutes of meeting which referred to nurses having paper copies of their protocols in case the computers system was not available, or there was a power cut.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There was evidence of learning from incidents and responding to risk had taken place and appropriate changes implemented. The practice looked at safety incidents and any concerns raised. They then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner.

Staff spoken with and records seen, confirmed staff had received training in medical emergencies including resuscitation techniques. All staff were trained in basic life support and the clinical staff in the treatment of anaphylactic shock (severe allergic reaction).

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment:

We found care and treatment was delivered in line with CCG and recognised national guidance, standards and best practice. For example, the clinicians used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as hypertension. We were told any updates were circulated and reviewed by the clinicians, these were discussed at their meetings and changes made as required.

The practice offered multi-morbidity clinic appointments where appropriate, for those patients who had more than one long term condition. Other clinics included: childhood immunisation and monitoring, antenatal and post natal clinics, general health checks and minor surgery.

The practice had registers for patient needing palliative care, diabetes, asthma, learning disabilities and COPD. This helped to ensure each patient's condition was monitored and their care regularly reviewed.

The practice used best practice care templates as well as personalised self-management care plans for patients with long-term conditions. This supported clinical staff as well as patients when agreeing and setting goals and these were monitored at subsequent visits.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was patients were cared for and treated based on need. The practice took account of patient's age, gender, race and culture as appropriate.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

Management, monitoring and improving outcomes for people:

We found there were mechanisms in place to monitor the performance of the practice and the clinician's adherence with best practice to improve outcomes for people.

We saw the practice had a system in place for monitoring patients with long term conditions (LTC) and this included asthma, hypertension, Chronic Obstructive Pulmonary Disease (COPD), diabetes and learning disabilities. Care plans had been developed and they had incorporated NICE and other expert guidance.

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). This aimed to improve outcomes for a range of conditions such as diabetes. The practice used the information they collected to help monitor outcomes for patients and the quality of services they provided.

We found clinical staff had a good awareness of recognised national guidelines. For instance they used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes and asthma. The practice had a system in place for completing clinical audit cycles and examples seen included COPD. We saw minor surgical procedures took place in the practice in line with the GPs registration.

The practice completed full health checks on new patients and followed up any identified health needs.

A palliative care register was maintained; the QOF data showed, in line with National targets the practice had regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed. This helped to ensure these patients received the best care possible.

Effective staffing:

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff.

The practice was a training practice for doctors who were training to be qualified GPs and they were supported by the GP partners and practice staff. There was an up to date induction pack and a practice registrar's guide 2014. The trainee GP confirmed the guide contained all relevant information and included local protocols, procedure and guidance for them to follow.

Staff confirmed and records showed, new staff were provided with induction training and mentors. They were able to access relevant up to date policy documents, procedures and guidance.

Good

Are services effective?

(for example, treatment is effective)

Staff had annual appraisals where they identified their learning needs. The practice had procedures in place to help ensure all staff kept up to date with both mandatory and non-mandatory training. These included training in, fire awareness, safeguarding vulnerable adults and children and basic life support. Staff confirmed they received training specific to their roles, for example, vaccinations and immunisation training and included any updates.

Working with colleagues and other services:
We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular meetings with multi-disciplinary teams within the locality.

Multidisciplinary meetings were held to discuss patients on the palliative care register and support was available irrespective of age.

Staff we spoke with felt they were listened to and involved in the running of the practice. There were clear lines of accountability and staff understood their roles.

The practice used a computer system to store patient records. Blood test results and hospital discharge letters were allocated to the duty GPs or the GP who had made the request for continuity of care and actioned where appropriate. Blood test results were also looked at by the trainee GPs for their learning.

Information sharing:
Staff had access to electronic systems relevant to their role and all staff had access to up to date practice policies and procedures. Staff told us they were kept informed by the practice manager if there had been any changes to policies and procedures.

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular meetings with the multi-disciplinary team within the locality. These included palliative care nurses, heart failure nurse specialist, and community matron.

The electronic system enabled timely transfer of information with the out of hour's providers and this included the local hospitals.

Weekly practice meetings also took place between the clinicians, practice manager and senior staff. This helped to share important information and included: updates of policies, protocols, audits, medicines prescribing information and case conference discussions.

Consent to care and treatment:
We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity to make decisions about their treatment.

Patients felt they could make an informed decision. They confirmed their consent was always sought and obtained before any examinations were conducted.

Health promotion and prevention:
All new patients were asked to complete a medical questionnaire, giving details of their medical history and were offered a health screen examination with a practice nurse.

All patients over 75 years had a named GP and received an annual health check. Patients with a long term condition or mental illness had an annual review of their treatment, or more often where appropriate. Dementia screening also took place.

Child health clinics were held for development assessments and a GP and nurse were in attendance for routine screening of infants and to give parents advice. Baby immunisation clinics were held weekly.

The practice provided a Well Woman Screening service, including smears, contraceptive advice, blood pressure and Hormone Replacement Therapy (HRT) checks.

The practice had a range of health information leaflet displayed in the practice informing patients about self-treatment of common illnesses and accidents. Their web site promoted information about how to become healthy and it provided links to other websites such as the NHS Patient Information websites.

Good

Are services effective?

(for example, treatment is effective)

Within the waiting area we saw there was a clinical information booklet. We were told this was for patients who wished to learn more about health.

Additional clinics and services were available for patients within the practice. These included a smoking cessation clinic. This had the benefit of providing local, accessible services for patients.

Good

Are services caring?

Our findings

We received 35 CQC comment cards where patients shared their views and experiences of the service. We also spoke with two patients on the day of our inspection; one who was a member of the patient participation group (PPG).

Respect, Dignity, Compassion & Empathy:
The practice team had been trained in customer services to try to ensure a positive service for their patients.

Staff were familiar with the steps they needed to take to protect people's dignity. There was a separate reception counter away from the main reception and consulting rooms should patients like to speak in private with a member of staff. All consulting rooms were private and patients who completed the CQC comment cards told us their privacy and dignity was always respected. We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, and satisfaction questionnaires sent out to patients. The evidence from these sources showed patients were satisfied with how they were treated. The practice was in line with the national average for its satisfaction scores on good or very good at treating patients with care and concern.

Care planning and involvement in decisions about care and treatment:
The data from the national patient survey showed the practice was in line with the national average for its satisfaction scores; it was good or very good at involving patients in decisions about their care. Patients we spoke with said they had their treatment fully explained to them and had been involved in decisions about their care and treatment. They also told us the staff were friendly and caring and they were always given time when seeing the GP or nurse.

Care plans were in place for patients with specific health needs and these included patients with long term conditions such as, asthma. They were adapted to meet the needs of each individual. This information was designed to help patients to manage their own health care and wellbeing to maximise their independence and also helped reduce the need for hospital admission.

Patient/carer support to cope emotionally with care and treatment:
We saw information in the practice about advocacy, bereavement support and counselling services. Staff were also aware of contact details for these services when needed.

The patients we spoke to on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required. The CQC patient comments cards also confirmed the practice staff were very supportive to them and their families.

Palliative care meetings with clinical staff and community health professionals were held to discuss patient treatment, care and support this ensured they received co-ordinated care and support.

A member of staff has been trained by the practice to acts as their patients' advocate. Patients discharged from hospital were contacted by this person. This personal contact helped to ensure any follow up appointments were actioned, immediately. In addition patients who needed support from other services were given the contact details.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs:
We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

We were told one of the GP partners attends the Doncaster Clinical Commissioning Group (CCG) locality meetings. As such, they engaged with other practices to discuss local needs.

We were also told, another of the GP partners was the Secretary of Doncaster Local Medical Committee.

The practice was accessible to patients with mobility difficulties. The consulting rooms were large with easy access for patients with mobility difficulties. There were toilets for disabled patients.

There was a baby changing area, and a small play area for children visiting the practice.

The patients had access to online and telephone translation services. However, we were told by staff the practice population was English speaking and therefore they had not had to use the service.

Tackling inequity and promoting equality:
The practice had extended opening hours on a Wednesday. This allowed for flexible access for patients including working age patients and those in full time education.

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.

Child health clinics were held for development assessments and a doctor and nurse were in attendance for routine screening and parental advice. Immunisations and vaccination clinics were also held.

All patients over 75 years had a named GP. There were systems in place for older patients to receive regular health checks, and timely referrals were made to secondary (hospital) care. Information was available to carers and the practice kept a register of these patients.

Patients with a long term condition such as asthma and diabetes, had care plans in place and this included those who were at risk of re-admission to hospital. These were shared with the patient and helped offer the patient a better overall experience in meeting their needs. Healthcare professionals were skilled in specialist areas and their on-going education supported them to follow best practice guidelines.

Access to the service:
Information was available to patients about appointments in their leaflet which was available in the waiting room and on their website.

The practice promoted the use of Skype and emails to communicate with their patients. This helped to offer the patient other ways of accessing their GP and a better overall experience in meeting their needs.

To help facilitate attendance for patients the practice had a doctor triage system; where the reception staff noted the patients name and telephone number and arrange for one of the doctors to call them back. The doctor would then direct the patient to the most appropriate person who was able to deal with the patient's problem. For example, this may include an appointment with a doctor or nurse.

Patients we spoke with told us this system worked well and they were able to have an appointment the same day when needed. They also told us they were able to book appointments in advance, for the follow up of their long term health condition.

On the day of our visit a patient who needed urgent medical attention, walked into the practice without an appointment. The practice staff alerted the GP who was on triage duty, and the GP responded immediately and met the patient need.

Opening times were Monday, Tuesday, Thursday and Friday 8.30am – 1pm and 1.30pm – 6pm, Wednesday 7.30am – 1pm and 1.30pm to 7.45pm. Extended opening hours were Wednesday 7.30am – 8am and 6.30pm to 7.45pm.

The practice also had a dedicated emergency telephone number, so patients were able to access staff when needed in an emergency situation.

When the practice was closed calls were diverted to the Doncaster Out of Hours service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Repeat prescriptions were able to be ordered on line; by post, fax and in person.

Listening and learning from concerns and complaints:

The practice had a system in place 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 information was available to help patients understand the complaints system and this was located in the practice leaflet, in the waiting room and on their web site. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One patient we spoke with told us they had made a complaint. They told us there had been a misunderstanding and the GP had handled the issue well and had followed their complaint procedure.

We reviewed three complaints received by the practice in 2014 and saw they were responded to in line with the practice procedure. We were told by the practice manager the outcomes of complaints, actions required and lessons learned were shared with the staff during their team meetings where appropriate; this was confirmed by the nursing staff.

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 vision was: "To provide exceptional NHS Family Medicine in first class surroundings for all the family, from sapling to great oak."

There was an established management structure within the practice. The practice manager, GPs and staff were clear about their roles and responsibilities and the vision of the practice. They worked closely with the local CCG and were committed to the delivery of a high standard of service and patient care. They wanted to continue to deliver personal services to their patients, which met their needs.

Monitoring took place, and this included audits to ensure the practice was delivering safe, effective, caring, responsive, and well led care.

Governance arrangements:
The practice had effective management systems in place. The practice had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation, were in date; reviewed and updated. We found clinical staff had defined lead roles within the practice. For example, the management of long term conditions, safeguarding children and vulnerable adults, and medication prescribing. Records showed and staff confirmed they had up to date training in their defined lead role.

The practice held meetings where governance, quality and risk were discussed and monitored.

One of the GPs partners regularly met and worked with the local CCG. The practice used the Quality and Outcomes Framework (QOF) and audits to measure their performance.

Leadership, openness and transparency:
The practice was committed to on-going education, learning and individual and team development of staff. The performance of staff was the subject of monitoring and appraisal at all levels; which reflected the organisational objectives. There were leading roles within the team for different aspects of the service. For example, the vaccinations/ immunisation programme.

Staff we spoke with told us all members of the management team were approachable, supportive and appreciative of their work and they felt valued. They had a proactive approach to incident reporting, team meetings between clinicians and management staff took place weekly and information was shared with all staff where appropriate.

Staff spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals; for example, health visitors.

In communicating with the patients, the practice used Skype and emails and one of the GP partners was using Twitter and Facebook.

Practice seeks and acts on feedback from its patients, the public and staff:
We were told by the practice manager, staff, and a patient that correspondence with the PPG was mostly by email or on the telephone. The practice manager emailed and spoke with the PPG when deciding the common themes patients were concerned about. The practice carried out a survey in 2014, and it was handed out over five consecutive days in the practice; 106 patients responded in total.

There were two main themes which came from the survey: firstly, patients would like more available appointments through on line booking. Ninety per-cent of patients who responded to the survey said they would use the on line appointment booking service. As a result of this the practice agreed to include this system in the way patients access the service. At the time of the visit the patients spoken with told us the system had recently been introduced.

Secondly, patients were asked whether they would like Cardio, Pulmonary, Respiratory (CPR) training provided at the surgery. Seventy seven per-cent of patients stated they would. As a result one of the GP partners told us they were developing a proposal for starting these sessions in the near future.

The practice newsletter reminded patients of events occurring in the practice and kept them up to date with points of interest. For example, confidentiality within the practice, information about the PPG, seasonal vaccinations, and awareness of the practice website.

Staff felt they could raise concerns at any time with the GPs and practice manager. They were considered to be approachable and responsive. The practice had gathered

Are services well-led?

Good

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

feedback from staff through a staff survey, meetings and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement:

We saw there was a system in place for staff appraisals and staff had mandatory training and additional training to meet their role specific, needs. Mandatory training included: fire safety awareness, safeguarding vulnerable adults and children. The practice had clear expectations of staff attending refresher training and this was completed in line with national expectations. Staff we spoke with told us they felt supported to complete training and could request additional training which would benefit their role.

Staff were able to take time out to work together on TARGET (Time for Audit, Research, Governance, Education and Training) days to resolve problems and share information which was used proactively to improve the quality of services. We saw minutes of meetings where issues had been discussed and proposed action as a result.