The Scott Practice

Quality Report

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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Key findings

Contents

Letter from the Chief Inspector of General Practice

This practice is rated as Outstanding overall.

(Previous inspection January 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Outstanding

Families, children and young people – Good

Working age people (including those retired and students – Good

People whose circumstances may make them vulnerable – Outstanding

People experiencing poor mental health (including people living with dementia) - Good

We carried out an announced comprehensive inspection at The Scott Practice on 21 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. Care and treatment was always delivered according to evidence- based guidelines.
- Those whose circumstances made them vulnerable, frail older people and those with multiple long term conditions were well supported by the practice who employed a pro-active care team.
- Staff involved and treated patients with compassion, kindness, dignity and respect.The practice was above average for its satisfaction scores on consultations with GPs and nurses.
- Recent improvements had been made to the telephone system and patients found it easy to use the appointment system and reported that they were able to access care when they needed it.
- There was innovation and service development and improvement was a priority among staff and leaders.
- At the core of the practices ethos, was learning and development across all staff groups.

We saw areas of outstanding practice:

- The practice used innovative and proactive methods to improve patient outcomes and worked with other local providers to share best practice. In October 2016

Summary of findings

the practice linked with six neighbouring practices to hold quarterly meetings with the wider multidisciplinary team which included a respiratory nurse, community geriatrician, a representative from the local social prescribing initiative, palliative care nurses, district nurses, heart failure nurse, social services and the falls team. This provided the opportunity to review those patients considered most at risk and a forum for sharing best practice and learning through review of case studies.

- The practice ensured that patients with complex needs, including those with life-limiting progressive conditions, were supported to receive coordinated care in innovative and efficient ways.The practice employed a care co-ordinator nurse to review and implement care plans for those patients whose circumstances may make them vulnerable. Initially, patients were assessed using a risk stratification tool which included review of patients living with dementia, learning difficulties, frailty, at risk of hospital admission, housebound, residing in care home or those with multiple long term conditions. The care co-ordinator had identified 255 patients at risk and 89% of these patients had agreed care plans in place.
- There was compassionate, inclusive and effective leadership at all levels. All leaders demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
- There was a demonstrated commitment to best practice performance and risk management systems and processes. The practice reviewed how they functioned to ensure that staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

The areas where the provider **should** make improvements are:

- Review monthly checks of emergency medicines and consider completing a risk assessment in the absence of keeping a stock of Atropine, a medicine to treat slow heart beat.

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

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
People with long term conditions	Outstanding
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Outstanding
People experiencing poor mental health (including people with dementia)	Good

The Scott Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector and a GP specialist adviser.

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 only visited the main site as part of this inspection.

The practice provides General Medical Services (GMS) for 14,262 patients. The clinical staff team work across both sites. There are nine GP partners, six male and three female, a managing partner/practice manager and a salaried GP. They are supported by a pro-active care nurse, two practice nurses, an advanced nurse practitioner, three healthcare assistants and a pharmacist. An experienced team of administrative and reception staff support the practice at both sites.

The practice opening hours at the Balby site are:

- 8am to 6.30pm Monday, Thursday and Friday
- 8am to 7pm on Tuesday
- 7am to 6.30pm on Wednesday

The Sprotborough site is open Monday to Friday 8am to 12.30pm and open until 4.30pm on two afternoons a week, days of which may vary.

The practice leaflet and web site include details of surgery and GP appointments times. GP appointments are available from 8.00am to 5.30pm each weekday, with extended appointment times on Tuesday mornings and evenings. Routine and specialist clinics such as long term condition management, minor surgery, ante-natal and family planning are also available.

Out of hours care can be accessed via the surgery telephone number or by calling the NHS 111 service.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use. However we noted emergency medicines were checked monthly rather than weekly as recommended by the Rescus Council UK. They were kept in sealed boxes and it was evident if they had been used. The practice did not keep a stock of atropine, an emergency medicine used to treat a slow heart beat. The lead GP told us a risk assessment would be completed.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

Good

Are services safe?

- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

The practice employed a clinical pharmacist to support patients with medication queries and undertake medication reviews. A new medication review template and protocol had been implemented to promote the appropriate safe prescribing of medicines. The template prompted clinicians to consider overuse, if the patient was taking multiple medicines and non-compliance.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. A GP took the lead for significant events and leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, the cold chain policy was reviewed following an incident. A lock for the medicines refrigerator was installed to reduce the risk of it being opened accidentally. The updated procedure was shared with staff at the clinical meeting and respective team meetings.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice and all of the population groups as good for providing effective services overall except for those whose circumstances may make them vulnerable which we rated outstanding.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical well-being.
- Staff prescribed a comparable number of hypnotic medicines. The practice score was 0.71 compared to the CCG average of 0.67 and the national average of 0.9.
- Staff prescribed a comparable amount of broad spectrum antibiotic items (11%) in comparison with the CCG average of 6% and the national average of 8.9%.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had a social media page with 414 followers to promote initiatives such as the sepsis, symptoms of meningitis and flu vaccination.
- Staff offered the flu vaccine to those over the age of 65 years and whose circumstances may make them vulnerable.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- GPs at the practice developed and maintained their areas of specialist interest. Patients could be referred to them directly for review prior to being referred to hospital consultants.
- The practice developed and hosted the pro-active care team, which included three pro-active care nurses and a healthcare assistant, to review and implement care plans for those patients whose circumstances may make them vulnerable. The practice had their own pro-active care nurse who was supported by a healthcare assistant. Initially, patients were assessed using a risk stratification tool which included a review of patients living with dementia, learning difficulties, frailty, at risk of hospital admission, housebound, residing in care home or those with multiple long term conditions. The pro-active care nurse had identified 255 patients at risk and 229 of these have care plans in place. Of that 168 patients had consented to an enriched summary care record. The enriched summary care record included the patient's significant medical history, anticipatory care information (such as information about the management of long term conditions), communication preferences, end of life care information, reasons for medications and a record of immunisations. It can be accessed by other care providers such as the out of hours service or community teams. Each patient with a care plan in place was asked to rate their confidence in their health needs and repeated when the care plan is reviewed. Through support of the team 23% of patients' confidence improved from not being very confident to being fully confident and a further 33% improved their confidence score.
- The pro-active care team held quarterly meetings with the wider multidisciplinary team which included a respiratory nurse, a community geriatrician, a representative from the local social prescribing initiatives, palliative care nurses, district nurses, heart failure nurse, social services and the falls team. This provided the opportunity to review those patients considered most at risk and a forum for sharing best practice and learning through review of case studies.

Older people: This population group was rated good because:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail were reviewed by the pro-active care nurse for a clinical review including a review of medication by the practice pharmacist.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. There were 1,151 patients' registered at the practice who were over the age of 75 and 80% had received the flu vaccine. Of those 767 had received an over 75's health check.
- The pro-active care nurse followed up all older patients discharged from hospital. They ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

Good

Are services effective?

(for example, treatment is effective)

People with long term conditions: This population group was rated good, in addition to the above, because:

- A dedicated member of the administrative team acted as the practice long term condition review co-ordinator. Regular searches of the patient record system were peformed to identify newly diagnosed patients with long term conditions.
- Patients with long term conditions would be invited to a structured annual review to check their health and medicines needs were being met during one appointment.
- Those with complex long term conditions were also reviewed at the monthly GP and pro-active care nurse meetings and the wider locality multidisciplinary meetings.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Of those patients with an irregular heart beat 92% were treated with blood thinning medicines which was comparable with the CCG average of 91% and the national average of 88%.

Families, children and young people: This population group was rated good because:

- The practice had a dedicated administrative lead to send out invitations for baby and childhood vaccinations. Historically uptake rates for the vaccines given were below the target percentage of 90%. The practice score ranged between 81% to 88% achievement for vaccinations for children five years old to the end of July 2016. However this had improved to an average of 91% for the year 2016/17. Clinicians would follow up any non-attenders.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long term medicines.
- The practice has a GP with a special interest in Paediatrics and children are referred to them prior to referral to secondary care.
- The practice was involved in the local CCG's enhanced safeguarding pilot and was one of only two practices carrying out assessments of looked after children.
- Staff liaised with the designated child and adolescent mental health services (CAMHS) for schools to support young people with their emotional and behavioural well being. The CAMHS worker would attend quarterly child information forum meetings as required.

Working age people (including those recently retired and students): This population group was rated good because:

- The practice's uptake for cervical screening for women for women aged 25 to 49 and for women aged 50 to 64 was 73%, which was in line with the 72% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Sixty seven patients aged between 18 and 19 had received the vaccine in the last 12 months.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. In the last 12 months 440 patients had attended health checks. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable: This population group was rated outstanding in addition to the above because:

- A GP took the lead for palliative care, supported by an administrative co-ordinator. Each patient on the end of life care registered had two named GP's so a named person could be contacted during the practice opening hours. End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Named GPs and practice staff offered bereaved families support to six months after the patient passed away.
- The practice held a register of patients living in vulnerable circumstances including homeless people, members of the travelling community and those with a learning disability. Homeless people used the practice address for other health related letters to be sent to.
- A member of staff took the lead for military veterans to ensure they were identified in referral letters for the (practice identified the rights of military veterans under the covenant).

People experiencing poor mental health (including people with dementia): This population group was rated good because:

- 75% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This lower than the national average of 84%.

Good

Are services effective?

(for example, treatment is effective)

- 95% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the local and national average of 91%. However the practice exception rate at 19.4% was higher than the CCG average of 8.8% and the national average of 6.8%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 97%; CCG 94%; national 90%).
- The practice hosted improving access to psychological therapies (IAPT) a national programme to increase the availability of 'talking therapies' on the NHS. (IAPT is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post-traumatic stress disorder).
- Practice staff undertook ward rounds three times a week at the local community hospital caring for patients with learning difficulties and those experiencing poor mental health to co-ordinate their care with other services involved.
- Staff had undertaken dementia friend training.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives. The most recent published Quality Outcome Framework (QOF) results were 99.9% of the total number of points available compared with the clinical commissioning group (CCG) average of 98.5% and national average of 95.6%. The overall clinical exception reporting rate was 15% which was higher than the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.). Staff explained that patients could decline review appointments by text message. A GP took the lead for reviewing those patients who excepted.

- The practice used information about care and treatment to make improvements. For example, staff reviewed all patients who had an intrauterine device fitted at the practice. A pack was also developed to provide information to patients before the procedure was performed.
- The practice was actively involved in quality improvement activity and nine clinical audits were in progress. For example, a recent two cycle clinical audit demonstrated patients taking an oral anti-fungal medicine had a blood test before and after treatment to check the medicine did not affect the patient and also were only prescribed a limited supply.

The practice was actively involved in research and worked in a cluster group with seven other practices and currently acted as the lead to co-ordinate clusters involvement in research. Of those 16 research studies the practice had signed up to 265 patients were involved. They included research into a number of long term conditions. For example, a study researching living with long term conditions, a study of womens' health and a study of patients with an irregular heart beat.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Good

Are services effective?

(for example, treatment is effective)

- The practice was a clinical placement area for both physcian assistants, medical and nursing students and allied health professionals. Staff were trained as mentors to support them during their placements at the practice.
- The practice facilitated GP trainees to support learning for the future primary care workforce. Staff we spoke with reported very positive experiences at the practice.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The care co-ordinator worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long term condition and carers. For example, those identified at risk of developing type 2 diabetes were referred to the NHS diabetes prevention programme to support people to make lifestyle changes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- Staff also referred patients to the social prescribing project in Doncaster. They had the option to prescribe non-medical support to patients. This included support for loneliness and social isolation and to provide information regarding housing issues or advice on debt. The practice had referred 66 patients to the scheme in the last 12 months.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice and all of the population groups as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We spoke with 11 patients and all but one of the 42 patient Care Quality Commission comment cards we received were very positive about the service experienced. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice. The less positive feedback did not relate to a specific theme.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 251 surveys were sent out and 107 were returned. This represented about 0.7% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 93% of patients who responded said the GP gave them enough time; CCG - 85%; national average - 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw; CCG and national average - 95%.
- 89% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 84%; national average - 86%.
- 91% of patients who responded said the nurse was good at listening to them; (CCG) - 92%; national average - 91%.
- 94% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw which was comparable to the CCG and national average of 97%.
- 92% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG and national average - 91%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice identified patients who were carers or had a carer through a variety of methods. For example, when registering at the practice, during consultations if they were accompanied by another and during flu clinics. The practice's computer system alerted GPs if a patient was a known carer or had a carer. The practice had identified 221 patients as carers (1.7% of the practice list).

- The care co-ordinator and other practice staff supported carers' by informing them of services that provided support and details of how to contact them. Carer's were invited for annual reviews and offered annual vaccinations.
- Staff told us that if families had experienced bereavement, their usual GP would contact them. This call was either followed by a consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services caring?

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 89% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 84% and the national average of 86%.
- 82% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 79%; national average - 82%.
- 89% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG and national average - 90%.
- 84% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - and national average - 85%.

Privacy and dignity The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice as outstanding for providing responsive services and for those whose circumstances may make them vulnerable and for people with long term conditions. The remaining population groups were rated as good.

The practice was rated as outstanding for providing responsive services because:

- Services were tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.
- There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, reception staff were trained in care navigation to offer the patient an appointment with the right person for the right amount of time and also signpost to other appropriate services if needed.
- Extended hours appointments were available on Tuesday evenings until 7pm and Wednesday mornings from 7.30am for working patients who could not attend during normal opening hours.
- Patients requesting a same day appointment would be initially triaged by a GP and then offered a face to face appointment if indicated. The triage GP worked along side reception staff in the office so calls could be transferred to them in an emergency or urgent advice sought.
- Telephone consultations were also available with all GP's for patients with on-going needs to facilitate continuity of care. Patients could request specific call back times as staff recognised it was not always convenient to answer a telephone call in the workplace.
- Care and treatment for patients with multiple long term conditions and patients approaching the end of life was coordinated with other services through the GP leads, practice pharmacist and administrators.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, for patients whose only barrier getting to the practice was lack of transport, a taxi could be provided.
- Staff accessed an electronic encyclopaedia of healthcare developed by the CCG, designed to give GPs and other clinicians based at local surgeries fast access to a wealth of information when they were seeing patients. It included referral forms to hospital consultants, contact details for local health services, and details of the 'pathways' of care patients follow according to their medical history. Staff told us by using the system it enhanced their knowledge of the local health and care system and enabled appropriate signposting to other services.
- The practice employed a pharmacist who performed medicine reviews, offered medicine advice to clinicians and patients and performed medicine audits.
- The practice held multidisciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team and whole practice meetings.
- The practice had a proactive approach to understand the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which was accessible and promoted equality.

Older people: This population group was rated good because:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- Older people were assessed for their level of frailty and those who were considered severely frail referred to the pro-active care nurse for full assessment and support.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Medicines delivery services could be arranged for housebound patients through the local pharmacies.

People with long term conditions: This population group was rated outstanding in addition to the above because:

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- The practice had a dedicated long term condition recall co-ordinator to call patients for a review in their birth month. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs. Patients would see the healthcare assistant to have the relevant tests performed and their medication would be reviewed by the practice pharmacist.
- GPs with specialist interests took the lead for each long term condition. For example, diabetes, respiratory and cardiac problems.
- Healthcare assistants had undertaken further skills training, supported and supervised by a GP, to undertake some specific patient investigations. For example, foot checks in diabetic patients and pulse checks in patients with an irregular heart beat.
- The practice held regular meetings with the local district nursing team and pro-active care co-ordinator to discuss and manage the needs of patients with complex medical issues. The Community Consultant Geriatrician attended the meetings and worked closely with the pro-active care team.
- A practice nurse and GP were undertaking further training to initiate insulin to patients.
- Practice nursing staff cared for patients with wounds that required complex dressings.

Families, children and young people:

This population group was rated good for responsive because:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- A congratulations card was sent to all mum's of newborn babies which included information of services offered at the practice.
- Staff were trained to offer contraceptive advice and fit coils and contraceptive implants.

Working age people (including those recently retired and students):

This population group was rated good for responsive because:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours Tuesday evening and Wednesday mornings. Each week 11 hours of appointments were available with GPs, practice nurse, pharmacist, advanced nurse practitioner and healthcare assistants.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

This population group was rated outstanding for responsive in addition to the above because:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Homeless people used the practice address for postal correspondence.
- Patients approaching end of life were allocated two named GP's. This provided continuity when patients and/or their carers contacted the practice as one of the GPs would be working. The appointment system alerted the GP to contact from the patient or their carer and the named GP would then ring or see the patient. If both GPs were on leave they would brief another GP to be the point of contact and inform the patient. Patients were reviewed at the weekly practice meeting and then the monthly multidisciplinary ream meeting where the patients notes would be updated accordingly during the meeting.
- Practice staff provided support to families of end of life patients upto six months after the bereavement of their loved one. A letter would be sent which included information about bereavement, support services and the support the practice could offer.
- A member of staff acted as the 'veterans' champion promote support services and to ensure referral letters captured relevant information for onward care and treatment.
- The practice identified those patients whose circumstances made them vulnerable who were not known to other services were referred to the pro-active

care nurse. Patients would be reviewed in either at the practice or their home setting and a plan of care agreed and referral to other services if needed. This initiative has been shared with other practices to implement and over a 12 month period resulted in the practice seeing a 17% reduction accident and emergency visits from patients who were referred to the service.

People experiencing poor mental health (including people living with dementia):

This population group was rated good for responsive because:

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Child and Adolescent Mental Health Service (CAMHS) workers attended monthly meetings at the practice to discuss young peoples needs.
- Improving access to psychological therapies (IAPT) is a national programme to increase the availability of 'talking therapies' on the NHS. (IAPT is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post-traumatic stress disorder). An IAPT counsellor held a clinic at the practice once a week.
- The practice implemented the 'The Herbert Protocol' introduced by South Yorkshire Police, the Alzheimer' s Society, health trusts and Dementia Action Alliances to provide police officers with early access to information when dealing with missing people living with dementia. All patients living with dementia registered at the practice were encouraged to complete the form which was designed to make sure that, if someone was reported missing, the police could access important information about that person as soon as possible. The form contained information about their medical status, mobility, access to transport , places of interest and daily routines. Once completed, copies were made and then available for use if the person should ever be reported missing. The idea is that speedy access to information would help officers track missing people more quickly.
- GPs performed a ward round three times a week at the local hospital for patients with learning disabilities and poor mental health. Patients could be referred to support services and other agencies to assist the patients stay in hospital and preparations for discharge.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.

They had collected data relating to the demand for appointments for all staff groups since 2005. This enabled the scheduling of staff rota's to meet varied seasonal demand. Also if reception staff noticed fluctuations in demand on the day, they could open more telephone or face to face appointments with relevant staff.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 251 surveys were sent out and 107 were returned. This represented about 0.7% of the practice population.

- 83% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) and the national average of 80%.
- 49% of patients who responded said they could get through easily to the practice by phone; CCG – 65%; national average - 71%.
- 66% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 71%; national average - 76%.
- 73% of patients who responded described their experience of making an appointment as good; CCG - 68%; national average - 73%.

The practice also received feedback from patients in various ways to review patient satisfaction with services offered.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Text messages were sent to those patients registered for the service, following their appointment to assess their satisfaction. Results from 1,060 text responses from the last 12 months indicated 88% of patients would recommend the practice to others.
- The patient participation group ran a conducted a survey in January 2017 to ask about the satisfaction with the triage system. 91% responded they were satisfied with their experience of the triage system.
- In addition the practice participated in a research project and as part of it 60 patients were canvassed for their satisfaction with the appointment booking system. 100% reported satisfaction with the system.

Following historical low satisfaction with telephone access to the practice the provider invested in a new telephone system which they have more control over and access to reporting functions. Since the installation there had been an increase in calls to the practice and the average time to answer was reducing. For example, in October 2017 there had been 7,100 calls to the practice with an average speed of answer of 3 minutes 20 seconds and in January 2018 there had been 7,700 calls with an average speed of answer 2 minutes 40 seconds. To achieve this more reception staff had been employed to answer the calls at peak times and a call divert function installed to provide the option for non-patient related calls to be answered by the relevant staff member.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 23 complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, following a delay in a referral to another service the procedure was reviewed and updated to include situations where the patient may be seen in another environment to ensure referrals were not delayed. Learning from this event was shared with staff at their meetings.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice, and all of the population groups, as outstanding for providing a well-led service.

The practice was rated as outstanding for well-led because:

- There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development and succession planning, which aimed to ensure that the leadership represents the diversity of the workforce.
- There was a demonstrated commitment to best practice performance and risk management systems and processes. The practice reviewed how they functioned to ensure that staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capability and integrity to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. The practice worked collaboratively with three other local practices to deliver improved services for patients. For example, the practice led on streamlining multidisciplinary reviews with other practices by setting up one meeting for all practices involved inviting both health and social care staff to deliver improved efficiency for the health economy and improved access.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. Succession planning was proactively managed by the practice team. The practice had a relatively low GP to patient ratio (1:809 compared with the CCG average of 1:1,712) and low staff turnover levels. The partners recognised the importance of supporting and training the future healthcare workforce.
- The practice was a training practice for GP registrars and had been selected to provide additional training and mentoring for GP registrars who required additional support. GP trainees spoke highly of the practice staff in supporting them and gaining valuable experience. The practice also facilitated clinical placements for early years medical student teaching, medical student teaching, physician associates and nursing student placements. Apprenticeship programmes were in place for reception and administrative staff and healthcare assistants.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, each GP took the lead for a clinical area and other systems such as finance, systems and information technology, human resources and clinical quality, access and business and training. Each staff group also had a named GP lead who would attend the groups meetings and work with them to improve services for patients. For example, a GP supported the scheduler and receptionists to improve access to appointments and provide flexibility in doing so.
- In addition to their practice responsibilities staff led on and facilitated training sessions for other practices in Doncaster, particularly for nursing and administrative staff.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Are services well-led?

Outstanding ☆

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

Culture

The practice had a culture of high-quality sustainable care.

- Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, meetings took place with people providing feedback and they were asked to comment on new processes as a result of their feedback. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were very positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was collected and used to ensure and improve performance. Performance information was combined with the views of patients. For example, staff and members of the patient participation group contributed to the implementation of the new telephone system to improve telephone access for patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Are services well-led?

Outstanding ☆

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

- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. For example, the practice had purchased a machine to measure a patient's breathing capacity that transmitted the results directly to the patient record system.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, staff and patients contributed towards research studies. Examples of which were to find out treatments that work better for patients and improve productivity in general practice.
- There was an active patient participation group. Members worked with staff to arrange information sessions for patients. The most recent one was well attended and linked with a charity to promote keeping well in the winter. In addition they also spent time in the practice promoting the benefit of online services to patients. Of those patients registered at the practice 22% had signed up for online services which was 10% above the local average.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice. For example, staff were keen to look at new ways of working and had implemented several new systems such as care navigation and the electronic encyclopaedia as well as the pro-active care nurse team.
- Practice staff adopted a team approach across the staff groups to identify and proactively address challenges and meet the needs of the patient population. For example, improvements with the appointment system.
- Staff knew about improvement methods and had the skills to use them.
- The practice was actively involved in research to improve care for patients.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.