Dr Karen Wagstaff - Barnburgh Surgery

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	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection visit on 20 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:

- The practice learned from significant events and incidents and took action to prevent their recurrence.
- All areas of the practice were visibly clean.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to help ensure they were up to date with best practice.
- The service was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- There were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw several areas of outstanding practice including:

- The GP is the CCG clinical lead for dementia and all staff at the practice were dementia friends trained. This helped to offer the patient a better overall experience in meeting their needs.
- The practice had participated in the pilot of 'Cantab mobile' a mobile screening tool which identified patients who were at risk of developing dementia.

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 procedures and local procedures in place to ensure any risks to patient's health and wellbeing was minimised and managed appropriately. The practice learned from incidents and took action to prevent recurrence. Medicines were stored and managed safely. The practice building was clean 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 people.

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. 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. They 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 patients. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. They were responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

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 when meeting their needs. Healthcare professionals were skilled in specialist areas and their ongoing education meant they were able to ensure best practice was being followed. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

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. Appointments were available with practice nurses and GP outside of school hours. 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. A full range of health promotion and screening clinics was available; these reflected the needs of this population group.

Summary of findings

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. The practice held a register of patients living in vulnerable circumstances, including those with learning disabilities. These patients received an annual health check and longer appointments were available where required. Access to translation services where available 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). One hundred per cent of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had in place advance care planning for patients with dementia. They worked in partnership with the local hospital dementia care team, for the benefit of patients. The practice had participated in the pilot of 'Cantab mobile' a mobile screening tool which identified patients who were at risk of developing dementia.

All staff were Dementia Friends trained and they planned to run dementia training for patients, their families and carers in the near future.

The practice had sign-posted patients experiencing poor mental health to various support groups and organisations. The practice had a system in place to follow up patients who had attended accident and emergency where there may have been mental health needs.

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.

Patient and comments from the CQC comment cards were positive about how the practice worked and met their needs. We saw many comments about the excellent care patients and their families had received from all members of the clinical team. They told us, the staff were caring, friendly, helpful, and treated them with dignity and respect. With the exception of one patient who experienced long waiting times for booked appointments to see the doctor, other patients reported the service was good. They said appointment times were kept and they were able to get an appointment the same day when needed.

Responses to the NHS patient survey identified: The GP and nurses were good or very good at treating patients with care and concern; patients were involved in decisions about their care, and when they wanted to see or speak to a GP or nurse from the practice, they were able to get an appointment.

Outstanding practice

- The GP is the CCG clinical lead for dementia and all staff at the practice were dementia friends trained. This helped to offer the patient a better overall experience in meeting their needs.
- The practice had participated in the pilot of 'Cantab mobile' a mobile screening tool which identified patients who were at risk of developing dementia.

Dr Karen Wagstaff - Barnburgh Surgery

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 Dr Karen Wagstaff - Barnburgh Surgery

Dr Karen Wagstaff GP practice is also known as Barnburgh Surgery, and is located in a rural area in Barnburgh, Doncaster, South Yorkshire.

The practice is a single handed general practitioner (GP) and uses locum GPs who are familiar with the service. A part time salaried GP has recently been appointed and is to join the practice at the beginning of February 2015. Working alongside the GPs are two practice nurses, and a health care assistants (all of whom are female). There is an experienced management team including, a practice manager and administration support/reception staff.

The practice has a Personal Medical Services (PMS) contract. PMS is a locally agreed alternative to General Medical Service (GMS) for providers of general practice. Their registered list of patients is 2,400. A high percentage of the population is elderly, from a mixture of deprived and efficient areas; non English speaking patients are in the minority.

This is a training practice for medical and nursing students and the practice also has an apprentice receptionist. The nurse placements are part of a pilot scheme to help encourage nurses on qualifying, to work in general practice.

The practice appointment times range between their opening times of: 8 am - 7 pm Tuesday and Wednesday; 8 am - 6.30 pm Monday, Thursday and Friday.

Home visits are made to those patients who are not well enough to access the surgery, and emergency appointments are available each day.

Weekends, bank holidays and when the practice is closed, calls are diverted to the Doncaster Out of Hours service.

A range of practice nurse led clinics are available at the practice and these include: vaccinations and immunisations, 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.

Detailed findings

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.

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 20 January 2015. During our inspection we spoke with staff including a GP, a nurse, a health care assist, practice manager, and reception staff.

We spoke with two patients visiting the practice, and 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 and incident reports and discussed these with staff. They were aware of the incidents and the action taken to try and prevent a similar situation from occurring. The QOF data showed there were no concerns relating to safety at this practice and they had a safe track record.

Learning and improvement from safety incidents:
The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We were told of an incident where two patients had a similar name and information had been logged in the wrong patient record. Staff told us they now check the patients date of birth as well as their name, to try to prevent a similar incident occurring. Staff were able to give other examples of incidents and the process used to report, record, and the improvement and learning which had taken place.

Reliable safety systems and processes including safeguarding:
There were policies and protocols for safeguarding vulnerable adults and children. With the exception of one staff who was new in their role, all 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. They knew how to contact the relevant agencies and we were told contact details were easy to access.

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.

We were told by the GP that new guidance with regards to the Mental Capacity Act (MCA) was to be discussed at the safeguarding team meeting in April, to ensure they were up to date.

In the practice waiting room and consulting rooms 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 they all had received chaperone training delivered by the GP. The also told us one of the nurses would normally carry out the role. The healthcare assistant was also booked to attend an accredited chaperone course in March 2015.

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 (including blood tests) and reviewing, such as Methotrexate. They also monitored and audited medicines to ensure the practice followed good practice guidance, published by the Royal Pharmaceutical society.

NHS prescribing indicators showed the practice was either average or better than average in their prescribing of medicines such as, Hypnotics, antibiotics and Non-Steroidal Anti-inflammatory drugs, when compared with the national average.

The GPs monitored patient's medicines and this included those patients who were discharged from hospital. Patients told us reviews of their medication had taken place and the frequency of the reviews was dependent on their individual needs.

We saw emergency equipment was available in the surgery which included emergency medicines. The practice had

Good

Are services safe?

arrangements for managing medicines to keep patients safe. Correct procedures were followed for the prescribing, recording, dispensing and disposal of medicines. Staff we spoke with were aware of the accessibility of emergency drugs, and the action they should take in an emergency situation.

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. 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 for staff.

We saw there was a sluice sink in the patient toilet and was told by the practice manager it was not used during surgery hours. We were also informed the GP had received local approval from the CCG to extend their premises and would be submitting plans to NHS England for national approval. We were also informed the extension would include a sluice sink which was not part of the patient toilet area, together with clinical and non clinical provision.

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).

The GP was a single handed practitioner and used locum GPs (the same four) who also worked in Doncaster and were familiar with the service. A part time salaried GP had recently been appointed and was to join the practice at the beginning of February 2015.

The practice manager told us there was a low turnover of staff and many of them had been working at the practice for several years. There was a rota system in place to ensure sufficient staff were on duty. In addition there were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We were told there was sufficient staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

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. Lead roles were undertaken by the GP, nurses and practice manager in areas such as, safeguarding, medicines management and infection control. They had systems for keeping staff informed and up to date/using the latest guidance. For example, safety alerts were circulated to staff

Good

Are services safe?

and relevant changes made to protocols and procedures within the practice. The practice manager and staff told us safety alerts were discussed and the information was reinforced.

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. Staff were aware of the protocols should an incident occur and this included emergency contact numbers.

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 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.

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 the GP and clinical staff 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 GP 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. 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. The practice had a system in place for completing clinical audit cycles and examples seen included cancer care. The QOF data showed the practice was better than average for maintaining a register of patients in need of palliative care/support irrespective of age, and multidisciplinary reviews of patients on the register take place at least three monthly. The practice also completed full health checks on new patients and followed up any identified health needs. This helped to ensure these patients received the best care possible.

Effective staffing:

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. We were able to review staff training records. We saw this covered a wide range of topics such as equality and diversity, dementia, safeguarding vulnerable adults and children, conflict resolution, health and safety, infection control, and basic life support.

The practice ensured all staff could readily update both mandatory and non-mandatory training and this was provided through e-learning and face to face training. The practice manager told us newly employed staff were supported in the first few weeks of working in the practice. The practice nurse also told us they had been supported from the university by a lead nurse who shadowed their work. All staff had access to relevant up to date policy documents, procedures and guidance.

The GP provider was up to date with their continuing professional development requirements. We saw evidence from the General Medical Council (GMC) they had been revalidated on the 8 January this year. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Good

Are services effective?

(for example, treatment is effective)

The nurses who worked in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must also undertake regular training and updating of their skills. We saw evidence the nurses were up to date with their registration and therefore able to continue to practice in the roles for which they were employed.

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. Staff confirmed they received annual appraisals and training specific to their roles, for example, vaccinations and immunisation training and this 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 those at risk. The QOF data showed these meeting were held at least three monthly and all patients on the register were discussed.

The GP was a member of the South West Locality CCG. They were the clinical lead for Dementia, and also lead for improving the community nursing in Doncaster and as such, they worked closely with the named community nurse.

The practice used a computer system to store patient records. Blood test results were received electronically and followed up by the GP where appropriate.

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.

Staff told us they had regular meetings and update meetings. These took place weekly and whenever there were things to be discussed. Although the practice manager did not take minutes of these meetings, the staff were able to describe the content of the discussions and any actions taken in response. In discussion with the practice manager they agreed to formalise these meetings and record the information discussed together with any action taken.

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, community matron, and the safeguarding teams.

The electronic system enabled timely transfer of information with the out of hour's providers and this included the local hospitals and community staff. The GP reviewed all information received and actioned where appropriate.

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. These 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 received routine health screening and those on regular medication were seen by the GP.

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.

All new parents received information informing them when their mother and baby checks and immunisations were due. Any patients who missed an appointment were followed up initially by telephone and a letter from the GP; their health visitor was also informed. The QOF information

Good

Are services effective?

(for example, treatment is effective)

showed the practice was performing well in all areas relating to the vaccination of children between the ages of 12 month and 5 year, and in the majority of areas were meeting the 100% target.

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 provided links to other websites such as the NHS Choices website.

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.

Respect, Dignity, Compassion & Empathy:
The practice was a Dementia Friendly practice and part of the Dementia Action Alliance, which is an organisation committed to transforming the lives of patients with dementia and their carers. The GP was lead for the CCG area and the staff team had been trained in dementia awareness. The practice staff told us they were committed to try to ensure a positive service for these patients.

Staff were familiar with the steps they needed to take to protect people's dignity. There was an electronic booking in system. This meant patients privacy was respected as they did not have to announce their name when visiting the practice. Consultations took place in rooms which gave patients privacy and dignity. Patients at the practice told us they were treated with kindness, dignity, respect and compassion whilst they received care and treatment. We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. The telephone answering at the practice was separate from the reception desk, therefore telephone conversations could not be overheard by other patients.

Responses to the NHS patient survey identified the practice was in line with the national average for its patient satisfaction scores. They scored good or very good at the GP and nurses 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. The plans were adapted to meet the needs of each individual. This information was designed to help patients manage their own health care and wellbeing to maximise their independence and also helped to reduce the need for hospital admission.

Patient/carer support to cope emotionally with care and treatment:
We saw information in the practice about advocacy, and bereavement support services. Staff were also aware of contact details for these services when needed. The practice also had a therapist and counsellor who visited the practice weekly.

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 when required. The CQC patient comments cards 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 helped to ensure they received co-ordinated care and support.

When the practice was notified of patients hospital discharge, they contacted the patient to check they had their care packages in place where needed, and had any information/ follow up appointments relating to their care.

A letter of congratulations is sent from the practice to new mums and information to remind them about reviews and vaccinations are included.

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 the GP was a member of the Doncaster, South West Locality, Clinical Commissioning Group. As such, they engaged with other practices to discuss local needs and service improvements that needed to be prioritised.

The practice was accessible to patients with mobility difficulties. The consulting rooms were accessible for patients with mobility difficulties. There were toilets for disabled patients, and mother and baby feeding /nappy changing facilities.

Patients had access to translation services when needed.

Tackling inequity and promoting equality:
The practice had extended opening hours on a Tuesday and Wednesday from 8am to 7pm. 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. For example, those patients who have a learning disability or dementia.

The practice had participated in the pilot of 'Cantab mobile' a mobile screening tool which identified patients who were at risk of developing dementia.

Child health, immunisations and vaccination clinics were 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 the practice waiting room and on their website. This included how to arrange urgent appointments and home visits and how to book and cancel appointments through the website.

The practice appointment times were Monday 8.30am -12md and 2.30pm - 5.30pm, Tuesday 9am -12md and 3pm - 7pm, Wednesday 8.30am -11.30am and 3pm -7pm, Thursday 8.30am -11.30am and 3pm - 6pm, and Friday 9am - 12pm and 4pm - 6pm.

A GP call back could be requested and the GP called the patient back within the hour. Should an emergency arise and a patient requests to speak with a GP, providing they were not in surgery the GP would speak with the patient immediately. However if the GP was in surgery, the staff would take the patients details and they would be called back within 10 minutes.

Home visits were available to those patients who were not well enough to access the surgery, and emergency appointments were available each day.

Weekends, bank holidays and when the practice was closed, calls were diverted to the Doncaster Out of Hours service.

Nurse appointment could be booked routinely for a variety of conditions and health promotion, including: asthma, COPD, diabetes, travel and childhood vaccines, and health checks.

Responses to the NHS patient survey identified patients were either 'Very satisfied' or 'Fairly satisfied' with their GP opening hours. They also stated that when they wanted to see or speak to a GP or nurse from the practice, they were able to get an appointment.

Feedback from the CQC comment cards identified, with the exception of one patient who experienced long waiting times for a booked appointment to see the doctor, the service was good. They said appointment times were kept and they were able to get an appointment the same day when needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Repeat prescriptions could be ordered on line, in person, or by repeat prescription arrangements which were offered by participating pharmacists.

Listening and learning from concerns and complaints:

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

We saw information was available to help patients understand the complaints system and this was located in the waiting room and on their web site.

The practice manager was the designated person who handled complaints in the first instance, and they told us all complaints were taken seriously. They had an open door policy for staff and patients so concerns or complaints could be responded to in a timely manner. We were also told the outcomes of complaints, actions required and lessons learned were shared with the staff during their meetings.

The patients we spoke with were happy with the care they received at the practice and they knew how to make a complaint should they need to. They also felt they would be listened to. We reviewed a complaint received by the practice in 2014 and saw they were responded to in line with the practice procedure. We were also 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 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:
There was an established management structure within the practice. The GP, practice manager and staff were clear about their roles and responsibilities and the vision of the practice. The GP was also a member of the Doncaster, South West Locality, Clinical Commissioning Group and the practice were committed to the delivery of a high standard of service and patient care.

Governance arrangements:
The practice had management systems in place. They had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. It also showed they were achieving in the upper quartile by having regular palliative care meetings, maintaining a register of patient needing palliative care, and those over 18 years of age with a learning disability.

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

Staff we spoke with told us all members of the management team were approachable, supportive and appreciative of their work. They had a proactive approach to incident reporting. Meetings were held and this included those with clinicians, nursing staff, and information was shared with the non-clinical staff where appropriate.

Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals in meeting patient's needs.

Practice seeks and acts on feedback from its patients, the public and staff:
The practice had gathered feedback from patients through the Patient Participation Group (PPG), practice and NHS patient surveys, comment cards and complaints received. The staff felt they could raise concerns at any time with either the GPs or practice manager, as they were considered to be approachable and responsive. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The PPG was made up of eleven members and we saw the practice had information in the practice and on their web-site encouraging patients to join the group.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. The survey included the availability of same day appointments and being able to speak with the GP. The results of the survey were positive. Most people felt they received same day appointments and were able to speak with a GP when needed.

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: safeguarding vulnerable adults and children and cardio pulmonary resuscitation training (CPR). 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 four times a year, 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. In discussion with the practice manager they agreed that minutes of these meetings would in future be written in greater detail, and show the information discussed together with any action taken.