Northfield Surgery

Quality Report

The Vermuyden Centre
Thorne
Doncaster
DN8 4BQ
Tel: 01405 812121
Website: www.northfieldsurgerythorne.co.uk

Date of inspection visit: 15 January 2018
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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

This practice is rated as good overall. (Previous inspection 31 August 2016 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

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 – Good

Families, children and young people – Good

Working age people (including those retired and students) – Good

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Northfield Surgery on 15 January 2018 as part of our inspection programme.

We found one area of outstanding practice:

- Staff had liaised with the different types of patient traveller groups and had developed Romany traveller and traveller patient participation groups which met every six months. Staff were working with the groups to increase the awareness and importance of immunisations and NHS screening services and to provide feedback on the services the practice offered.

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. It ensured that care and treatment was delivered according to evidence- based guidelines.
- We saw staff involved and treated patients with compassion, kindness, dignity and respect. The practice had historically low patient satisfaction scores from the GP national patient survey. However, the provider had developed an action plan to address the issues.

Summary of findings

- A new telephone system had been installed to improve telephone access to the practice. Care navigation had also been introduced and patients told us improvements had been seen.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

- Provide a chaperone training update for healthcare assistants.
- Consider developing a schedule for continuous quality improvement activity and include review dates.
- Review the process to respond to complaints to ensure that it includes keeping records of all investigations undertaken.

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

Northfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser, a CQC inspector and a member of the CQC medicines team.

Background to Northfield Surgery

Northfield Surgery is registered with the Care Quality Commission to provide GP services from The Vermuyden Centre Fieldside, Thorne, Doncaster, South Yorkshire, DN8 4BQ and is located approximately five miles north east of Doncaster town centre. The practice provides primary medical care services for 9,797 patients under the terms of the national NHS General Medical Services contract. Further information can be found on the practice website www.northfieldsurgerythorne.co.uk .

The catchment area, which includes Thorne and Moorends, includes former mining communities and travellers groups and is classed as within the third most deprived areas in England. Income deprivation indices affecting children (25%) and older people (22%) are higher than the clinical commissioning group (CCG) average of (22% and 19%) and England (19% and 20%) averages. The age profile of the practice population is broadly similar to other GP practices in the Doncaster CCG area.

There are two male GP partners and one salaried female GP. They are supported by two long term locum GPs, an advanced nurse practitioner/nurse manager, two trainee nurse practitioners, three practice nurses, two healthcare assistants, a practice manager and a management and administrative team. The practice opening hours are:

- Monday, Wednesday, Thursday and Friday from 8am until 6pm.
- Tuesday 8am to 8.30pm.

The practice leaflet and web site include details of surgery and GP appointment times. GP appointments are available from 8am to 5.30pm each weekday, with extended appointment times on Tuesday evenings.

The practice operates from a purpose built health and social care building that contains another GP practice, a community library, a pharmacy and is the base for other NHS community staff.

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 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. Members of the nursing team acted as chaperones. The healthcare assistants had not had any recent training for the role and had received a DBS check. The practice manger told us training would be included on the next learning day.
- 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

Arrangements for managing medicines were checked at the practice. Staff showed us policies which had been regularly reviewed covering all aspects of the prescribing and management of medicines.

Staff regularly checked stock medicines were within expiry date. There were appropriate arrangements in place for the disposal of waste medicines and facilities for the safe disposal of cytotoxic medicines.

Repeat prescriptions were signed before being issued and there was a process in place to ensure this occurred. Blank computer prescriptions and pads were stored securely, and there was a system in place to track their movement which met with recommendations made in national guidance.

We saw a system in place to ensure the safe handling of requests for repeat prescriptions, including high risk medicines. We checked records for patients who were receiving high risk medicines and found they had all had the required monitoring carried out or the patient had been contacted to chase up outstanding blood tests.

Good

Are services safe?

The lead GP told us that for people with long term conditions, repeat medicines were re-authorised dependent on either annual or six monthly medicine reviews. This meant that patients were being properly reviewed to ensure their repeat medicines remained safe and appropriate, in particular those with long term conditions and those taking multiple medicines.

The practice had a process in place to manage information about changes to patients' medicines received from other services. We saw that details of medicines prescribed by secondary care were correctly recorded on the clinical system to support safe prescribing.

The practice responded appropriately to medicines alerts, medical device alerts, and other patient safety alerts, and we saw records of the action taken in response to these. There were arrangements in place for the recording of significant events involving medicines; the practice had acted adequately to investigate these incidents or reviewed systems andprocesses to prevent reoccurrence.

We asked to see examples of quality improvement activity, for example prescribing audits. One full-cycle audit had been completed in the last 12 months and an audit schedule was in place to ensure further audits were carried out in 2018. There was evidence of the practice accessing their prescribing data and benchmarking against other local practices. The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.

We checked emergency medicines stored in treatment rooms and medicines refrigerators and found they were stored securely and access restricted to authorised staff. There were adequate stocks of oxygen and a defibrillator.

Refrigerator temperatures were being recorded in line with national guidance. Vaccines were administered by nurses and healthcare assistants using directions which had been produced in line with national guidance.

Track record on safety

The practice had reviewed the safety systems to include:

- 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. Leaders and managers supported them when they did so. Staff developed an incident escalation process to ensure incidents were reported to the practice leads and escalated to external agencies where necessary.
- 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 pathway followed for review of patients with diabetes was reviewed and shared with staff to promote consistency of managing diabetes. This was shared with staff at a clinical meeting and circulated to all clinical staff to implement. It was also shared with other practices at a clinical commissioning group event.
- The practice learned from external safety events as well as patient and medicine safety alerts. In addition the clinical staff reviewed every new cancer diagnosis at the monthly clinical meetings.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as for providing effective services overall and across all population groups.

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 lower number of hypnotics medicines. The practice score was 0.50 compared to the CCG average of 0.67 and the national average of 0.9.
- Staff prescribed a lower amount of antibiotic items prescribed that were broad spectrum antitbiotic items (3%) in comparison with the CCG average of 4.35% and the national average of 4.71%
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice had a social media page with 333 followers to promote initiatives such as the weight loss group or stay well messages.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs.
- 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 911 patients' registered at the practice who were over the age of 75. Of those 63 who were not regular attenders at the practice had received a health check the last 12 months.

People with long term conditions:

- Patients with long term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP and nursing staff worked with other health and care professionals to deliver a coordinated package of care. Staff had recently updated the long term condition protocol for patients with diabetes to reflect NICE guidance. A consultant with a specialism in diabetes had facilitated a training session for practice staff to support the implementation of the updated protocol.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Of those patients with an irregular heart beat 90% were treated with blood thinning medicines which was comparable with the CCG average of 91% and the national average of 88%.
- Of those patients with chronic obstructive airways disease 95.4% has an assessment of their breathlessness using the medical research council dyspnoea scale which is comparable to the CCG average of 92% and national average of 90%.

Families, children and young people:

- Childhood immunisations were below the national childhood vaccination programme. Uptake rates for the vaccines given were below the target percentage of 90%. The practice score ranged between 84% to 84.9% achievement for vaccinations for children five years old and under. The provider had addressed this by employing a practice nurse who was also a health visitor and provision of specific mother and baby drop in clinics twice a week.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long term medicines.

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

- The practice's uptake for cervical screening was 85.4%, which was above the 80% coverage target for the national screening programme. However the practice exception rate at 12.6% was higher than the CCG average of 5.4% and the national average of 6.7%. Staff explained they were working with a number of local groups to promote cervical screening and a member of the nursing team was starting to offer cervical screening appointments on Tuesday evenings.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. 747 health checks had been undertaken in the previous 12 months. There was appropriate follow-up

Good

Are services effective?

(for example, treatment is effective)

on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice had achieved the second most health checks in the Doncaster area for the year 2016/17 and received an award for this.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice manager would contact the carers for patients whose care plan had changed every Friday to ensure they were aware of the out of hours contact numbers and support available.
- 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.

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

- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average of 84%. However the practice exception rate at 19.4% was higher than the CCG average of 8.8% and the national average of 6.8%.
- All patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. However the practice exception rate at 40.3% was higher than the CCG average of 19.1% and the national average of 12.5%. Staff explained the high exception reporting rate was due to patients' non-compliance attending appointments. Staff would attempt to contact patients but often they changed their mobile telephone numbers and did not inform the practice. The practice had not removed any patients from the list who did not attend appointments.
- 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 100%; CCG 94%; national 91%).
- 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 also hosted counsellors from an independent charity three times a week to provide group and one to one counselling for a number of issues. Staff told us this service was very popular with patients.

Monitoring care and treatment

The practice had a 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 99.4% 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 exception reporting rate was 12.6% which was higher than the national average of 9.6%. (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.)

The practice used information about care and treatment to contribute towards quality improvement activity. For example, following receipt of guidance from the National Institute of Health and Care Excellence (NICE) staff performed a review of patients presenting at the practice with uncomplicated urinary tract infections. Of those urine samples sent for microbiology, 40% came back with a urinary tract infection despite all samples showing indication of infection when initially tested by practice staff. The urinary tract protocol was reviewed to include only having one set of dipsticks open at one time and only treat patients who had four symptoms or more with a three day course of antibiotics. This resulted in £34,000 potential saving for the practice due to less urinary samples being sent for analysis and also the specific number of antibiotics prescribed for a urinary tract infection had reduced by 25% from September 2017 to October 2017.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

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.

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 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 experiencing isolation and carers. For example, staff referred patients to the counselling service to promote better health and well-being.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, the practice facilitated a weightloss group every Tuesday evening which was open to patients and people from the surrounding area.
- 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 63 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

We observed 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 six patients and all but one of the 10 patient Care Quality Commission comment cards we received were positive about the service experienced. Comments included 'the doctors and nurses are caring and helpful', 'staff are caring' and 'reception staff are helpful'. This was reflected in line with the results of the NHS Friends and Family Test where 87% of respondents were likely to recommend the service to friends and family. The less positive comment related to not being listened to by a member of staff.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with less compassion, dignity and respect. 277 surveys were sent out and 125 were returned. This represented about 1.2% of the practice population. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 56% 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%.
- 55% of patients who responded said the GP gave them enough time; CCG - 85%; national average - 86%.
- 78.8% of patients who responded said they had confidence and trust in the last GP they saw; CCG and national average - 95%.
- 51% 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%.
- 79% of patients who responded said the nurse was good at listening to them; (CCG) - 92%; national average - 91%.
- 88% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 95% 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%.
- 77% 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%.
- 68% of patients who responded said they found the receptionists at the practice helpful; CCG average 85% and national average - 87%.

The provider continually monitored the GP patient survey scores and in response completed their own survey. They acknowledged at the times when the national survey was taken there had been a change in nursing and administrative staff teams. In response a practice survey was completed and an action plan was developed. The plan included improvements to technology, patient engagement and staffing. For example, a new telephone system was installed to improve telephone access to the practice. They had identified a member of staff received more complaints from patients about their communication style and this was fed back to the staff member and monitored which resulted in the reduction in the number of complaints received. Reception and administrative staff were co-located downstairs to improve communication for patients and also staff trained in care navigation and administrative roles so they could access information patient's requested rather than referring to a colleague. An external review had also been completed which noted the practice had identified the areas for improvement and were working towards achieving their action plan.

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.

Good

Are services caring?

- Staff had developed information folders in nine different eastern european languages that were available in reception for new patients registering at the practice. They contained a the country's flag (for easy identification), a welcome note, practice opening hours and information leaflets about NHS screening programmes patients maybe requested to participate in. For example, cervical, breast and bowel cancer.
- 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 by asking them during consultations. A member of the administrative team had recently been selected to become the practice carer champion. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 338 patients as carers (3.4% of the practice list).

- Practice staff supported carers' to help ensure that the various services carers were coordinated and effective. 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. People could also be referred to the counselling service located in the building for bereavement support.

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

- 51% 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%.
- 51% 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%.
- 74% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG and national average - 90%.
- 72% 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%.

Staff also had been on a local radio show to promote the work of the practice and changes implemented.

Feedback from a local care home was positive about the support the residents received from the practice staff and also staff had a good understanding of their needs.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice had reviewed how it organised and delivered services to meet patients' needs and took account of patient needs and preferences in the scheduling of appointments.

- The practice understood the needs of its population and tailored services in response to those needs.
- Appointments were offered at the Practice between 8am to 6pm every weekday apart from Tuesday when they were offered until 8.30pm.
- Patients requesting a same day appointment would be initially triaged by a nurse and then offered a face to face appointment if indicated.
- The practice held six weekly multidisciplinary meetings and invited health visitors, district nurses, midwives, safeguarding leads (children and adults), heart failure nurse, school nurse, palliative care (nurse and consultant), community geriatrician, dietician, local nursing home representatives and pharmacists to discuss and manage the needs of patients with complex medical issues.

Older people:

- 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.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions:

- Patients with a long term condition received an annual review to check their health and medicines needs were being appropriately met.
- A weekly weight loss group held on Tuesday evenings was formed to support patients and those living locally to lose weight. Staff did not promote any specific weight loss programme but provided the opportunity for weekly weigh in sessions so patients could monitor their progress and receive support from the peer group. Patients could choose to be weighed or measured as staff recognised some medical conditions affected body weight. One patient shared with us they had lost 14.4 kilograms and had significantly reduced their daily insulin intake.

Families, children and young people:

- 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.
- Staff had identified an increase in the number of young people coming to the practice with mental health issues relating to bullying. In partnership with the counselling service, a drop in clinic every Tuesday evening was established for young people and their parents to provide information, support and counselling specific to young people. In addition to this practice staff liaised with the school nurse and local police to address the issue of bullying in the local area.

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

- 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 on Tuesday evenings.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- 11% of the practice population had signed up for online services which was above the local average of 8%.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Staff had liaised with the different types of traveller groups to hold a six monthly patient participation event specific to that group. Staff used this as an opportunity to provide feedback on the services the practice offered and promote NHS screening initiatives.
- The practice provided evidence of their work to support patients at risk and their collaborative work with other agencies to find support for these patients.
- The premises had been assessed as a safe place for adults with a learning disability to go to when they were out and about in Thorne if they felt unsafe or unwell.
- Three members of staff had been trained in learning disability reviews. In order to reduce fear and anxiety often caused by attending the practice and undergoing procedures such as blood tests or cervical screening, staff had implemented a programme of desensitisation. This included visits to the practice to familiarise patients with the surroundings and providing replica products to hold and feel.
- The practice had good links with the local food bank and could refer patients there. Staff and patients' collected food and gifts to donate to the centre in December 2017. This was a big success and they continued with the collection to donate items on a regular basis.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Most staff were trained as dementia friends.
- Those patients who failed to attend for booked appointments at the practice were proactively followed up by a phone call from a member of staff.

Timely access to the service

Patients had previously reported that they did not have access to timely appointments and practice staff had recognised this and took action to address it.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and national averages.

- 55% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average and the national average of 76%.
- 30% 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 - 81%; national average - 84%.
- 59% of patients who responded said their last appointment was convenient; CCG - 79%; national average - 81%.
- 40% of patients who responded described their experience of making an appointment as good; CCG - 68%; national average - 73%.
- 27% of patients who responded said they don't normally have to wait too long to be seen; CCG - 50%; national average - 58%.

Staff identified telephone access to the practice was an issues as they had no control over the number of telephone lines coming in to the practice and the messaging system. The provider had commissioned and installed a new telephone system that provided greater flexibility to meet the practices needs.

Since the survey 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. Some patients we spoke with told us they were reluctant to share such information with receptionists which resulted in them being offered an appointment with a nurse trained in minor illness. The provider was working with patients to promote the use of care navigation and the benefits to the patient. For example, notices in the practice and on the practice website.

Two nurses were undertaking the nurse practitioner course to enable them to prescribe medicines to offer more minor illness appointments to patients.

We spoke with seven patients on the day of inspection. Three had appointments made for them at their previous appointment and the other four had rang the practice that morning and been offered an appointment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Following the publication of the GP patient survey the provider completed their own survey of 50 patients following implementation of some of the changes. The findings were:

- 94% of respondents were satisfied with the practices opening hours.
- 74% of respondents who required an urgent appointment were offered one.
- 6% wishing to see a specific GP were offered an appointment on the same day and 62% were offered an appointment the following day.

The practice manger told us there had been a significant reduction in the number of complaints the practice received since the new telephone system had been installed.

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 and it was easy to do.
- The complaint policy and procedures were in line with recognised guidance. Thirty three complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way. However we found the provider did not always keep copies of the investigations undertaken as part of the complaints process.
- 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 an investigation into the late running of appointments the provider reviewed and implemented an updated protocol to ensure patients were briefed if appointments did not run to time. Staff also received feedback and their appointment times reviewed to ensure various appointment lengths were available for specific procedures.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Since our last inspection a new senior leadership team had formed which consisted of the two GP partners, the nurse manager and the practice manager. An independent review of the practice, commissioned by the CCG, was completed in June 2017. The report identified the management team had the foundations for good governance and were making a positive difference to the performance of the practice. The leadership team had developed a practice strategy which was reviewed monthly and progress documented.

- Leaders had the experience, capacity and skills 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.
- 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.

Vision and strategy

The practice reviewed the vision to deliver high quality care and promote good outcomes for patients.

- There was a practice philosophy and supporting business plans to achieve priorities.
- Staff were aware of the practice philosophy and their role in achieving it.
- The practice 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.

Culture

Staff described the culture of the practice improving over the past nine to twelve months. Staff stated they felt respected, supported and valued. They were proud to work in the practice and their focus was 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, staff described the learning from an incident involving one member of staff which ultimately affected other staff. Staff came together to review the incident, make recommendations for the future and share the learning with each other. 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, other than the practice manager, received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. The practice manager's appraisal was scheduled in the diary for January 2018.
- 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. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

The leadership team told us they had focused on developing clear responsibilities, roles and systems of accountability to support good governance and the management of the practice over the last 18 months.

- 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.

Are services well-led?

Good

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- The practice subscribed to a suite of general practice policies. They had developed their own clinical protocols and procedures and activities to ensure safety and to assure 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 medicine 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. We noted the majority of audits had been as a result of information received by the practice. For example, from NICE. The practice did not have a plan of audit for the next 12 months.
- The practice business continuity plan was under review as the telephony provider had changed. Staff we spoke with were aware of the contingencies should there be a major incident.
- 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. For example, the review of patients with uncomplicated urinary tract infections resulting in the savings from sending urine samples to the laboratory for analysis.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- 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 submitted data or notifications to external organisations as required.
- There were 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 were recruiting new members to a virtual patient participation group (PPG) as existing members who attended face to face commitments had changed. Following feedback about the difficulty to get through to the practice by telephone a new telephone service was commissioned and installed. The new service gave staff much more control over the number of lines available, messaging services and telephone call diverts.

- There were active Romany traveller and traveller patient participation groups which met every six months. Staff were working with the groups to increase the awareness and importance of immunisations and NHS screening services.
- The service worked with stakeholders about performance.
- Practice staff participated in fundraising events to raise money for local and national charities.
- The practice also held educational events for patients. For example, a dementia awareness day.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- 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.