# Bentley Surgery

## Quality Report

128 High Street
Doncaster
DN5 0AT
Tel: 01302 874551
Website: www.bentleysurgery.co.uk

Date of inspection visit: 4 December 2017
Date of publication: 31/01/2018

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

**This practice is rated as Outstanding overall.**
(Previous inspection January 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Oustanding

Are services well-led? - Outstanding

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

Older People – Good

People with long-term conditions – Outstanding

Families, children and young people – Outstanding

Working age people (including those retired and students – Good

People whose circumstances may make them vulnerable – Outstanding

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

We carried out an announced comprehensive inspection at Bentley Surgery on 4 December 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. Care and treatment was always delivered according to evidence- based guidelines, for example in relation to prescribing medicines for an irregular heart beat.
- Frail older people were well supported by the practice-employed care coordinator and their engagement with social prescribing.
- Staff involved and treated patients with compassion, kindness, dignity and respect.The practice was above average for its satisfaction scores on consultations with GPs and nurses.
- Patients found it easy to use the appointment system and reported that they were able to access care when they needed it.
- There was innovation and service development and improvement was a priority among staff and leaders.
- Data showed that the practice was performing highly when compared to practices locally and nationally.
- At the core of the practices ethos, was learning and development across all staff groups.

# Summary of findings

- Feedback from patients was consistently positive and higher than local and national averages.

We saw areas of outstanding practice:

- The practice used innovative and proactive methods to improve patient outcomes and worked with other local providers to share best practice. In October 2016 the practice linked with three neighbouring practices to hold quarterly meetings with the wider multidisciplinary team which included a respiratory nurse, community geriatrician, a representative from the local social prescribing initiative, palliative care nurses, district nurses, heart failure nurse, social services and the falls team. This provided the opportunity to review those patients considered most at risk and a forum for sharing best practice and learning through review of case studies.
- The practice ensured that patients with complex needs, including those with life-limiting progressive conditions, were supported to receive coordinated care in innovative and efficient ways.The practice employed a care co-ordinator nurse to review and implement care plans for those patients whose circumstances may make them vulnerable. Initially, patients were assessed using a risk stratification tool which included review of patients living with dementia, learning difficulties, frailty, at risk of hospital admission, housebound, residing in care home or those with multiple long term conditions. The care co-ordinator had identified 140 patients at risk and 89% of these patients had consented to an enriched summary care record.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.For example, a GP encouraged a group of patients to establish a support group for people with fibromyalgia. (Fibromyalgia is a long term condition that causes pain all over a persons body). The group met monthly at the practice and people from other practices were invited. The GP would attend with updates about therapies and treatments.

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

# Summary of findings

## The six population groups and what we found

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

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

# Bentley 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.

## Background to Bentley Surgery

Bentley Surgery is registered with CQC to provide GP services from 128 High Street, Bentley, Doncaster, DN5 0AT and is located approximately two miles north of Doncaster town centre. The practice provides primary medical care services for 7,298 patients under the terms of the national NHS General Medical Services contract. Further information can be found on the practice website www.bentleysurgery.co.uk.

The catchment area, which includes villages local to the surgery, former mining communities and three traveller sites, is classed as within the second most deprived areas in England. Income deprivation indices affecting children (30%) and older people (26%) are significantly higher than the CCG (25% and 18%) and England (20% and 16%) averages. The age profile of the practice population is broadly similar to other GP practices in the Doncaster CCG area. However, there are more children under the age of 10 years old registered at the practice. The practice has seen an increase in patients registering, 216 in the last year and 508 patients in the last five years.

There are five GP partners (two male and three female) at the practice who are supported by two salaried GPs. There is a lead nurse, three practice nurses, two healthcare assistants, a phlebotomist and an experienced management and administrative team. The practice is a training practice for GPs and a clinical placement area for medical and nursing students and physicians assistants.

The practice opening hours are:

- Monday, Wednesday, Thursday and Friday from 8.00am until 6.00pm.
- Tuesday from 7.30am until 7.30pm.

The practice leaflet and web site include details of surgery and GP appointments times. GP appointments are available from 8.00am to 5.30pm each weekday, with extended appointment times on Tuesday mornings and evenings.

Routine and specialist clinics such as long term condition management, minor surgery, ante-natal and endometrial biopsy diagnostic testing are also available. Out of hours care can be accessed via the surgery telephone number or by calling the NHS 111 service.

Good

# Are services safe?

## Our findings

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

**Safety systems and processes**

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

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

**Risks to patients**

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

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

**Information to deliver safe care and treatment**

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

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

**Safe and appropriate use of medicines**

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

The practice employed a clinical pharmacist to support patients with medication queries and undertake medication reviews. A new medication review template and protocol had been implemented to promote the appropriate safe prescribing of medicines. The template

prompted clinicians to consider overuse, if the patient was taking multiple medicines and non-compliance. The clinical pharmacist was available to talk with patients on the telephone or in person as requested as room availability allowed.

**Track record on safety**

The practice had a good safety record.

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

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, the pathway followed for patients with persistent symptoms was reviewed and shared with staff to promote consistency of managing urinary tract problems. This was shared with staff at a clinical meeting and circulated to all clinical staff to implement.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. In addition the clinical staff reviewed every new cancer diagnosis and non expected patient death at the monthly clinical meetings.

Outstanding ☆

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice as outstanding for providing effective services and for those with long term conditions, families, children and young people, those whose circumstances may make them vulnerable and and those experiencing poor mental health. The population groups older people and those of working age are rated as good.**

**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. However we noted some of the Medicines and Healthcare products Regulatory Agency (MHRA) were not included in the updates. The practice received these updates via the clinical commissioning group (CCG) updates and the clinical assessment system updates. They raised this with the CCG and MHRA to review recent updates and ensure they were included and also reported this as an incident for further investigation.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical well-being.
- Staff prescribed a lower number of hypnotic medicines. The practice score was 0.52 compared to the CCG average of 0.67 and the national average of 0.9.
- Staff prescribed a lower amount of broad spectrum antibiotic items (3.38%) 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.
- The practice had a social media page with 194 followers to promote initiatives such as the flu vaccine, the NHS Diabetes Prevention Programme and care navigation.
- Staff offered the flu vaccine to those over the age of 65 years and whose circumstances may make them vulnerable. The practice achieved the third highest vaccination rate in Doncaster for the year 2016/17.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- GPs at the practice developed and maintained their areas of specialist interest. Patients could be referred to them directly for review prior to being referred to hospital consultants. This resulted in a lower rate of referrals to secondary care. For example, the referral to outpatient clinics per 10,000 population for the practice was 161 compared with the CCG average of 294. Of those referred 26 per 10,000 were discharged following the first appointment compared to the CCG average of 48 per 10,000 patients.
- The practice employed a care co-ordinator nurse to review and implement care plans for those patients whose circumstances may make them vulnerable. Initially, patients were assessed using a risk stratification tool which included review of patients living with dementia, learning difficulties, frailty, at risk of hospital admission, housebound, residing in care home or those with multiple long term conditions. The care co-ordinator had identified 140 patients at risk and 89% of these patients had consented to an enriched summary care record. The enriched summary care record can include the patient's significant medical history, anticipatory care information (such as information about the management of long term conditions), communication preferences, end of life care information, reasons for medications and a record of immunisations. It can also be accessed by other care providers such as the out of hours service or community teams.
- The care co-ordinator reviewed all attendances at accident and emergency on a monthly basis and emergency hospital admissions. Practice patients had a lower attendance at accident and emergency and usage of the same day health centre compared to other local practices. For example, patients registered at the practice spent 189 hours in accident and emergency per month compared to the local average of 212 hours. Attendance at the same day health centre by patients registered at the practice was low at 1.26% compared to the local average of 2.33%.
- In October 2016 the practice linked with three neighbouring practices to hold quarterly meetings with the wider multidisciplinary team which included a respiratory nurse, community geriatrician, a representative from the local social prescribing initiative, palliative care nurses, district nurses, heart failure nurse, social services and the falls team. This provided the opportunity to review those patients considered most at risk and a forum for sharing best practice and learning through review of case studies. For example, the end of life care package was reviewed and

updated following review of the care provided to a patient. Following the review the best practice prescribing guidelines for end of life care was routinely included in the package for all patients to promote consistency in prescribing medicines.

Older people:

This population group was rated good because:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail were reviewed to the care co-ordinator for a clinical review including a review of medication by the practice pharmacist.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. There were 532 patients' registered at the practice who were over the age of 75. Of those 93% had been seen within the last 12 months.
- The care co-ordinator followed up all older patients discharged from hospital. They ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice had purchased a new electrocardiogram machine which transmitted the test results straight to the patient record system for prompt review by the GP.

People with long term conditions:

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

- 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 care co-ordinator worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Of those patients with an irregular heart beat 99% were treated with blood thinning medicines which was higher than the CCG average of 91% and the national average of 88%.
- Since April 2017 staff had referred 21 patients at high risk of developing type 2 diabetes to the NHS diabetes prevention programme. This was the second highest number of referrals from practices in the area for this time period.
- Of those patients with chronic obstructive airways disease 98% had received an assessment of their breathlessness using the recommended scale to assess how a patient's breathlessness affects their mobility.

Families, children and young people:

This population group was rated outstanding because:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%. The practice score ranged between 94.5% to 100% achievement for vaccinations for children five years old and under. Practice nurses would routinely contact parents or carers of children on the same day of any missed immunisation appointments to discuss and re-schedule another appointment.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long term medicines.
- The practice nursing team worked closely with the midwife who held a weekly clinic at the practice. Patients were referred to the practice nurse for family planning advice and members of the practice nursing team were trained to insert birth control implants.
- Staff liaised with the designated child and adolescent mental health services (CAMHS) for schools to support young people with their emotional and behavioural well being. The CAMHS worker would attend quarterly child information forum meetings as required.

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

This population group was rated good because:

- The practice's uptake for cervical screening was 82%, which was in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Forty nine patients aged between 18 and 19 had received the vaccine in the last 12 months.

Outstanding ☆

# Are services effective?

## (for example, treatment is effective)

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Eighty six health checks had been undertaken in the previous 12 months. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

This population group was rated outstanding because:

- 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 were working towards gold standard end of life care. Following review of an incident the staff had developed an end of life care pack for staff and patients. It included resources for patients and also prescribing guidelines for staff.
- 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):

This population group was rated outstanding because:

- 84% 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%.
- 96% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the local and national average of 91%.
- 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 98%; CCG 94%; national 91%).
- The practice hosted improving access to psychological therapies (IAPT) a national programme to increase the availability of 'talking therapies' on the NHS. (IAPT is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post-traumatic stress disorder).

**Monitoring care and treatment**

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results were 99.5% of the total number of points available compared with the clinical commissioning group (CCG) average of 98.5% and national average of 95.6%. The overall clinical exception reporting rate was 7% which was lower than the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

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

**Effective staffing**

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

Outstanding ☆

# Are services effective?

## (for example, treatment is effective)

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice was a clinical placement area for both physcian assistants, medical and nursing students and allied health professionals. Staff were trained as mentors to support them during their placements at the practice.
- The practice was a placement area for GP trainees to facilitate learning for the future primary care workforce.

**Coordinating care and treatment**

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

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

**Helping patients to live healthier lives**

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

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

**Consent to care and treatment**

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

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

Good

# Are services caring?

## Our findings

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

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We spoke with six patients and all of the 21 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 332 surveys were sent out and 101 were returned. This represented about 1.3% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% 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%.
- 88% of patients who responded said the GP gave them enough time; CCG - 85%; national average - 86%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw; CCG and national average - 95%.
- 92% 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%.
- 96% of patients who responded said the nurse was good at listening to them; (CCG) - 92%; national average - 91%.
- 96% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 97% 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%.
- 95% 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%.
- 95% of patients who responded said they found the receptionists at the practice helpful; CCG average 85% and national average - 87%.

**Involvement in decisions about care and treatment**

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

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

The practice identified patients who were carers by asking them during consultations. However staff acknowledged there were others who accompanied friends and family members to the practice who could be considered carers. This was not normally documented within the person's notes. The practice manager told us this would be reviewed. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 86 patients as carers (1.1% of the practice list).

- The care co-ordinator and other practice staff supported carers' by informing them of services that provided support and details of how to contact them. Carer's were invited for annual reviews and offered annual vaccinations.

Good

# Are services caring?

- 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.

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

- 92% 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%.
- 90% 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%.
- 93% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG and national average - 90%.
- 92% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - and national average - 85%.

**Privacy and dignity**

The practice respected and promoted patients' privacy and dignity.

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

Outstanding ☆

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice as outstanding for providing responsive services and for those with long term conditions and those whose circumstances may make them vulnerable. The population groups older people, families and young people, those of working age and those with experiencing poor mental health are rated as good.**

**Responding to and meeting people's needs**

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Appointments were offered at the Practice between 8am to 6pm every weekday apart from Tuesday when they were offered from 7.30am to 7.30pm.
- 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.
- Patients requesting a same day appointment would be initially triaged by a GP and then offered a face to face appointment if indicated. Telephone consultations were also available with all GP's for patients with on-going needs to facilitate continuity of care. Patients could request specific call back times as staff recognised it was not always convenient to answer a telephone call in the workplace.
- The provider had identified the facilities and premises required updating and expanding. A risk assessment of the premises had been completed to identify areas of risk and building improvement plans had been drawn up as part of the premises improvement scheme. However this was on hold as they were awaiting the outcome of another building proposal in partnership with other services.
- Staff from the practice attended the local annual gala to reach out to people who did not attend the practice regularly. Members of the patient participation group supported staff to promote the work the practice was doing and promote a seasonal health initiative. Staff were available to perform health checks on those people who requested it. Following the checks a person was diagnosed with type two diabetes and another with high cholesterol and are now receiving care and treatment.
- Care and treatment for patients with multiple long term conditions and patients approaching the end of life was coordinated with other services through the care co-ordinator.
- Staff accessed an electronic encyclopaedia of healthcare developed by the CCG, designed to give GPs and other clinicians based at local surgeries fast access to a wealth of information when they were seeing patients. It included referral forms to hospital consultants, contact details for local health services, and details of the 'pathways' of care patients follow according to their medical history. Staff told us by using the system it enhanced their knowledge of the local health and care system and enabled appropriate signposting to other services.
- The practice employed a pharmacist to offer medicine advice to clinicians and patients and perform medicine reviews.

Older people:

This population group was rated good because:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- 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:

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

- Patients with a long term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice had been commended by the CCG as one of the third highest in administering the flu vaccine to their patients in 2016/17

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

- Staff encouraged and supported patients to be involved in monitoring and managing their health.For example, a GP encouraged a group of patients to establish a support group for people with fibromyalgia. (Fibromyalgia is a long term condition that causes pain all over a persons body). The group met monthly at the practice and people from other practices were invited. The GP would attend with updates about therapies and treatments.

Families, children and young people:

This population group was rated good because:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

This population group was rated good because:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours on Tuesdays.
- Telephone GP consultations, early morning and late evening appointments were available which supported patients who were unable to attend the practice during normal working hours.
- 13% of the practice population had signed up for online services which was 5% 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:

This population group was rated outstanding because:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice identified those patients who were housebound or may have problems getting to the surgery due to mobility or health problems and had no regular nursing input. Initially the practice identified 140 patients under this criteria. The care co-ordinator would review the patient in their home setting and compile a care plan and make referrals to other services if required. This initiative has been shared with other practices to implement and resulted in the practice seeing a reduction in the number of unplanned home visits requested by this group of patients.

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

This population group was rated good because:

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Staff were all trained as dementia friends.
- The practice implemented the 'The Herbert Protocol' introduced by South Yorkshire Police, the Alzheimer' s Society, health trusts and Dementia Action Alliances to provide police officers with early access to information when dealing with missing people living with dementia. All patients living with dementia registered at the practice were encouraged to complete the form which was designed to make sure that, if someone was reported missing, the police could access important information about that person as soon as possible. The form contained information about their medical status, mobility, access to transport , places of interest and daily routines. Once completed, copies were made and then available for use if the person should ever be reported missing. The idea is that speedy access to information would help officers track missing people more quickly.
- Those patients who failed to attend for booked appointments at the practice or hospital were proactively followed up by a phone call from a GP.

**Timely access to the service**

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.
- Staff followed two rotas, one in the summer months and another in winter months. The provider identified they needed to provide more on the day appointments in winter months due to seasonal related symptoms.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mostly above local and national averages. This was supported by observations on the day of inspection, in our discussions with patients and completed comment cards.

- 91% 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%.
- 84% of patients who responded said they could get through easily to the practice by phone; CCG average – 65%; national average - 71%.
- 81% of patients who responded said their last appointment was convenient; CCG - 79%; national average - 81%.
- 84% of patients who responded described their experience of making an appointment as good; CCG - 68%; national average - 73%.
- 78% of patients who responded said they don't normally have to wait too long to be seen; CCG - 50%; national average - 58%.

In addition data showed that patients registered at the practice used the same day health centre and out of hours service less than other practices in the area. For example, the same day health centre usage was 1.2% compared with the local average of 2.3%.

Staff identified by increasing the number of telephone appointments patients could have with staff reduced the capacity for incoming calls. The provider had installed additional telephone lines to the building to accommodate this.

Practice nursing staff also identified they were seeing more patients with complex dressings. The provider had employed a treatment room nurse who was due to start at the practice mid December 2017 who was trained in complex wound dressings.

A member of the patient participation group was working with Healthwatch to address why people missed appointments across all Doncaster practices. Staff analysed the number of missed appointments each month and broke it down into the age range of patients not attending. This enabled them to raise awareness of missed appointments through appropriate communication methods. For example, in September 2017 there were 143 missed appointments and 62 of these were for patients aged between 20 years old to 39 years old. Staff used the social media page to alert patients to this. In November 2017 there were 47 missed appointments from the same age group.

**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. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Eight complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way. All complaints were raised as an incident and investigated in the same way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, an investigation into a delay with practice referrals to secondary care resulted in an update to the procedure to include a telephone call to follow up that faxes sent were received. Staff told us they were briefed of the update following the investigation and the learning discussed at the administrative team meeting.

# Are services well-led?

Outstanding ☆

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

## Our findings

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

**Leadership capacity and capability**

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

- 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. The practice worked collaboratively with three other local practices to deliver improved services for patients. For example, multidisciplinary reviews had been streamlined by setting up one meeting for the three practices inviting both health and social care staff to deliver improved efficiency for the health economy and improved access.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Succession planning was proactively managed by the practice team. The practice had a relatively low GP to patient ratio (1:1,215 compared with the CCG average of 1:1,712) and low staff turnover levels. The partners recognised the importance of supporting and training the future healthcare workforce. The practice was a training practice for GP registrars and had been selected to provide additional training and mentoring for GP registrars who required additional support. GP trainees spoken to on the day of the inspection, reported high satisfaction. The practice also facilitated clinical placements for medical, nursing and physcian associate students.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, each GP took the lead for a specific area such as finance, systems and information technology, human resources and clinical quality and business and training.
- In addition to their practice responsibilities clinical staff had lead roles at the CCG as the Chair of the CCG, end of life care, locality lead and lead for primary care. A GP was the vice chair of the local Health and Well Being Board and another GP organised the clinical training days for all GP practices in the area.

**Vision and strategy**

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Strategies and plans were aligned with plans in the wider health economy and there was a demonstrated commitment to a system wide collaboration and leadership. For example by establishing and facilitating a fybromyalgia support group for the whole community not just practice patients.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. For example, the provider had a business development plan which encompassed the need for improving the practice premises of which staff and patients were engaged with and contributed to.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population engaging with other health and social care providers. For example, offering contraceptive advice and implants to young people and recording the alcohol intake of all patients.
- The practice planned its services to meet the needs of the practice population. For example the employment of a care coordinator to support frail patients in their own homes to ensure their medical and social needs were met.
- The practice monitored progress against delivery of the strategy.

**Culture**

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

- Staff stated they felt respected, supported and valued. There were high levels of satisfaction across all staff groups, demonstrated by a very low staff turnover for many years. They were proud to work in the practice.

# Are services well-led?

Outstanding ☆

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

- The practice focused on the needs of patients and worked to initiate and then deliver innovative to improving the health and well being of their patients. For example referrals to the social prescribing service.
- Leaders and managers acted on behaviour and performance consistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. 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. The staff meeting structure as well as the inclusive culture of the practice supported this. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received regular annual appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. For example, the advanced nurse practitioner received regular clinical supervision with a GP.
- There was a strong emphasis on the safety and well-being of all staff. They recognised that staff retention was integral to delivering a high quality service and encouraged staff development in line with the needs of the individual, as well as the practice, and worked hard to ensure high staff satisfaction.
- 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**

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

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

**Managing risks, issues and performance**

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of 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. For example the practice's proactivity in improving their antibiotic prescribing to ensure good antimicrobial stewardship.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

**Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

# Are services well-led?

Outstanding ☆

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

- The practice used performance information which was reported,monitored and managed and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Engagement with patients, the public, staff and external partners**

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, staff and members of the patient participation group attended the annual local gala to promote practice initiatives and reach out to people who did not attend the practice regularly.
- There was an active patient participation group (PPG) who were actively engaged with the practice. Some of the projects the PPG were involved in included raising the cleaning standards in the practice by performing the infection prevention and control audit. PPG members engaged with the building development plans and had chosen furniture for the waiting area. The group had promoted the flu campaign by welcoming patients to the open flu clinics and promoting the local support groups.
- More recently the PPG addressed an issue patients had with one of the local pharmacies by arranging a meeting with an area manager to raise the issues on behalf of the patients to try to resolve them.
- The service was transparent, collaborative and open with stakeholders about performance.

**Continuous improvement and innovation**

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

- There was a focus on continuous learning and improvement at all levels within the practice. For example, staff were keen to look at new ways of working and had implemented several new systems such as care navigation and the electronic encyclopaedia.
- Central to the culture of the practice was one of learning and development. The practice was a training practice for others and supported their own staff in their learning journey.
- 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.