

The Village Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Village Practice on 6 January 2015. Overall the practice is rated as good.

Specifically we rated the practice as good in providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw two areas of outstanding practice:

- All staff within the practice were dementia friends trained. This helped to offer the patient a better overall experience in meeting their needs. Dementia Friends training supports people to learn more about what it is like to live with dementia.
- The practice had easy read books available during consultations to assist patients with a learning disability to understand conversations about their treatment.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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

Good



Are services effective?

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

Good



Are services caring?

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

Good



Are services responsive to people's needs?

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

Good



Are services well-led?

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity

Good



Summary of findings

and held regular meetings. Patients and staff felt valued and a proactive approach was taken to involve and seek feedback from patients and staff. What about their strategic plan? Is that relevant to include here?

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

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

Good



People with long term conditions

The practice is rated as good for the care of people with long term conditions such as diabetes or asthma. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There was a dedicated GP who took the lead for patients with a learning disability.

The practice had easy read books available during consultations to assist patients with a learning disability to understand conversations about their treatment.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable people and had provided information to people in circumstances that made them vulnerable about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). During the past year, every person who had sought support due to their experience of poor mental health had received a comprehensive, agreed care plan that had been documented in their clinical record.

The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. All staff within the practice were 'dementia friends' trained. This helped to offer the patient a better overall experience.

Good



Summary of findings

What people who use the service say

We spoke with three patients and two members of the patient participation group (PPG) on the day of our visit. Patients told us appointments ran on time and if there were delays the reception staff informed them of this. They told us that treatment options were discussed during consultations.

We received 45 CQC comment cards which patients had used to record their experience of the service they

received from the practice. All of the comment cards were very complimentary about the practice and the staff. Many patients commented on the care and treatment they had received by both reception staff and clinical staff within the practice, describing them as 'exemplary' 'exceptional' and 'outstanding'. They told us clinicians listened to them, explained treatments and involved them in decisions about their care.

Outstanding practice

- All staff within the practice were dementia friends trained. This helped to offer the patient a better overall experience in meeting their needs.
- The practice had easy read books available during consultations to assist patients with a learning disability to understand conversations about their treatment.

The Village Practice

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 and two further CQC inspectors.

Background to The Village Practice

The Village Practice is located in the Armthorpe area of Doncaster. The practice serves a population of approximately 5,449 patients.

The practice was formed in 1993 and provides services from a two storey building, with all patient services been provided on the ground floor.

The service is provided by one senior GP partner (male) and two GP partners (male). Working alongside the partners are two practice nurses and a health care assistant. The clinical team are supported by a practice manager, assistant practice manager and a team of administrative and reception staff.

The practice has a General Medical Services (GMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

The Village Practice offers a range of book on the day and pre-bookable appointments between 8.00am and 5.30pm Monday to Friday with the exception of alternate Wednesdays when the practice is closed for training.

When the practice is closed, out of hours cover for emergencies is provided by the NHS 111 service.

A wide range of services are available at the practice and these include: minor surgery, family planning and specialist clinics such as asthma, diabetes and smoking cessation.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission (CQC) at that time.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, including the NHS England local area team and Doncaster Clinical Commissioning Group (CCG), to share what they knew with us.

We carried out an announced inspection at The Village Practice on 6 January 2015. During our inspection we spoke with staff including three GPs, two practice nurses, the practice manager and two members of the reception team.

Detailed findings

We spoke with three patients on the day of our visit and two members of the patient participation group. We observed how patients were spoken to on the telephone and in the reception area. We also reviewed 45 CQC comment cards where patients had shared their views and experiences of the practice.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable

People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included reported incidents, national patient safety alerts, clinical audits, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We reviewed safety records, incident reports and saw evidence in minutes of clinical meetings where these were discussed. This showed the practice had managed these consistently and could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events and complaints and evidence the practice had learned from these. For example, a prescribing error had occurred due to two patients having similar names. As a result of the incident the practice had added an alert on the clinical system to highlight any patients with similar names.

Incidents were recorded using the practice's own in-house system and also recorded using an electronic system which enabled the practice to share information with the Clinical Commissioning Group (CCG). The benefit of this was to identify any themes locally and learn from them.

We spoke with two members of the reception team who told us that incident forms were available in the practice manager's office and these would be completed and handed to the practice manager who would decide on the most appropriate response. They told us that incidents were discussed regularly at the practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and adults whose circumstances may make them vulnerable. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff we spoke with were aware of their responsibilities and knew how to share

information, record safeguarding concerns and how to contact the relevant agencies in both working hours and out of hours. Safeguarding policies, procedures and the contact details of relevant agencies were available and easily accessible for all staff.

The practice had a designated GP who took the lead in safeguarding children and adults whose circumstances may make them vulnerable. The GP had completed enhanced safeguarding training to level 3. All staff we spoke with were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern.

The practice held a safeguarding register and held regular multidisciplinary meetings with other professionals, such as the health visitor, to discuss concerns and share information about children and adults whose circumstances may make them vulnerable, who were registered at the practice.

There was a chaperone policy in place and notices in each clinical room and the reception area advising patients of this service. Nurses and reception staff provided this service and had appropriate checks through the disclosure and barring service (DBS). We spoke with the practice manager and two members of the reception team who told us a chaperone could be requested by the GP or the patient.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Are services safe?

We spoke with two members of the reception team who told us the checks undertaken by the practice prior to dispensing a prescription. They told us they checked the name, date of birth, address and in some cases the last three digits of the telephone number.

Cleanliness and infection control

We found the premises to be clean and tidy. We saw there were cleaning schedules in place and records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

An infection prevention and control (IPC) policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal Protective Equipment (PPE) including disposable gloves and aprons were available for staff to use. Hand washing sinks with hand soap, antibacterial gel and towel dispensers were available in treatment rooms.

Sharps bins which are used for the safe disposal of needles and other potentially dangerous equipment, were appropriately located and labelled. The practice had access to spillage kits and the staff we spoke with were aware of the location of the kits.

There was a nominated lead for infection control who could support staff regarding any infection control issues.

We spoke with the practice manager who told us that a legionella assessment had been carried out in April 2013 and we saw documentation to confirm this.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw there was a schedule in place to ensure all equipment was tested and maintained regularly.

All portable electrical equipment was routinely tested. The sample of equipment we inspected had up to date Portable Appliance Tests (PAT) stickers displaying the last testing date. We saw a certificate confirming calibration of equipment had been carried out in November 2014.

Staffing and recruitment

Records we looked at contained evidence confirming that the appropriate recruitment checks had been undertaken

prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

We spoke with the practice manager who told us they were able to plan staffing levels by monitoring the telephone system and looking at the number of calls unanswered. The staff rota would be adjusted to minimise this occurrence.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing issues and the arrangements for managing emergencies.

The practice had developed clear lines of accountability for all aspects of patient care and treatment.

There was evidence the practice learned from incidents and responded to identified risk. The practice looked at safety incidents and where concerns had been raised, they looked at how this could have been managed better or avoided.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was

Are services safe?

available including access to a nebuliser and appropriate tubing and masks. Nebulisers can be used for emergency treatment of many respiratory diseases such as chronic obstructive pulmonary disease (COPD).

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We found from our discussions with the GPs and advanced nurse practitioner that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs and advanced nurse practitioner told us they led in specialist clinical areas such as diabetes, heart disease and asthma. This allowed them to focus on specific conditions.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice held a variety of different clinics to meet the needs of people using the service including travel vaccinations, contraception and sexual health.

The practice had registers for patients needing palliative care, and treatment for diabetes, asthma and COPD. This helped to ensure each patient's condition was monitored and their care was regularly reviewed. Additionally, regular palliative care meetings were held and they included other professionals involved in the individual patient's care. For example palliative care nurses and district nursing staff.

Staff at the practice told us they promoted health initiatives during consultations with patients'. We noted health promotion information available in practice waiting areas and on the practice website.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients.

Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had effective systems in place for how they completed clinical audit cycles. We were provided with examples of two clinical audits which had been undertaken in the last 18 months.

One audit looked at how the practice performed in an important aspect of its cervical screening programme. The audit wanted to see how the practice rate of 'inadequate smears' compared against the national rate. An 'inadequate smear' is when the cells collected during the procedure cannot be analysed, and so the test has to be repeated. The practice performed well with 1.1% of smears undertaken being 'inadequate' against a national average of 2%

The second audit we reviewed related to Amiodarone monitoring. Amiodarone is a medicine used to treat heart rhythm disorders. As a result of this audit the practice had identified actions and recommendations. We saw the practice had also conducted a re-audit, completing the clinical audit cycle.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures.

We reviewed the QOF figures for 2013/14 and saw the practice was above both the local CCG and NHS England average achievements for all of the clinical domains.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with essential training courses such as annual basic life support and safeguarding adults and children.

GPs were up to date with their continuing professional development requirements and all had either been revalidated or had a date for revalidation. Every GP is

Are services effective?

(for example, treatment is effective)

appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practise and remain on the performers list with NHS England.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, cervical cytology (cervical smear testing) and childhood immunisations. The practice nurses we spoke with were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills.

All staff felt supported in their role and confident they could raise any issues with the practice manager or the GPs. The staff we spoke with confirmed they had annual appraisals and were supported to undertake any relevant training.

We spoke with the practice manager who told us that Dementia Friends training had been provided for all staff to support them in their roles. Dementia Friends training supports people to learn more about what it is like to live with dementia.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those complex needs. It received blood test results, X ray results, and letters from the local hospital, including discharge summaries, electronically. There were systems in place in relation to receiving, passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs or children for whom there are safeguarding or child protection concerns. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

We spoke with staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us how they referred patients for secondary (hospital) care and tried to book an

appointment using the Choose and Book system. The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

We spoke with the practice manager who told us that clinicians within the practice were proactive in following up results, for example, ultra sound and x-rays. They told us that individual tasks were set up on the clinical system to prompt the clinician to chase up results.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out of hours provider to enable patient data to be shared in a secure and timely manner.

Staff used an electronic patient record to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from the hospital, to be saved on the system for future reference.

Electronic systems were in place for making referrals which, in consultation with the patients, could be done through the Choose and Book system.

We saw evidence where appropriate information was shared with other services and professionals to meet patients' needs. Shared access of specific information was available to the health visiting team, particularly around safeguarding children.

Consent to care and treatment

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

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

Patients felt they could make an informed decision. They confirmed their consent had been sought and obtained before any examinations and were aware of how to request a chaperone should they require one.

Health promotion and prevention

Are services effective?

(for example, treatment is effective)

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

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

A GP and nursing team led on the management of long term conditions (LTCs) of patients in the practice. They proactively gathered information on the types of LTC patients present with and had a clear understanding of the number and prevalence of conditions being managed by the practice.

We spoke with a GP at the practice who told us they knew their patients well and that whilst some patients could

attend the surgery in summer, adverse weather and their frailty may prevent them from doing so during the winter months. They told us the practice would carry out home visits to administer the flu vaccine to ensure all patients received this. The QOF data we reviewed showed the practice were performing well in meeting the flu vaccination against the influenza targets.

The practice had a range of health information leaflets displayed in the practice informing patients about self-treatment of common illnesses and accidents. Their web site provided links to other websites such as the NHS Choices website.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 45 completed cards and all of the comment cards were very complimentary about the practice and the staff. Many patients commented positively on the care and treatment they had received by both reception and clinical staff within the practice. They told us clinicians listened to them, explained treatments and involved them in decision about their care.

We spoke with two members of the patient participation group (PPG) on the day of our inspection and three patients who were attending the practice for an appointment. They told us they were satisfied with the level of care provided by the practice and said their privacy and dignity were respected.

Staff and patients told us all consultations were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained.

We observed staff interacting with patients in the reception area and saw that this was open, friendly and caring.

We were told there was a room available for patients who wished to speak to a member of the reception team in private.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice 'good'

in these areas. For example, data from the national patient survey showed 92% of respondents said the GP was good at explaining tests and treatment and 95% felt the nurse was good at involving them in decisions about their care.

The patients we spoke with on the day of our inspection told us health issues were discussed with them in a way they could understand. They felt involved in decision making about their care and treatment. They told us they felt listened to and had enough time during a consultation to make an informed decision about the choice of treatment they wished to receive.

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

Patient/carer support to cope emotionally with care and treatment

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

Palliative care meetings with clinical staff and community health professionals were held to discuss patient treatment, care and support. We were told this ensured patients received coordinated care and support.

We spoke with the practice manager who told us the practice kept a register of all bereavements and the GPs at the practice would contact the family of the bereaved to offer support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they engaged regularly with the Doncaster Clinical Commissioning Group (CCG) and other agencies to discuss the needs of patients and service improvements.

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. Longer GP appointments were available for patients who had complex needs.

Patients with more than one long term condition had the option of a single health check to avoid the need for multiple appointments and the practice had easy read books available during consultations to assist patients with a learning disability to understand conversations about their treatment.

We spoke with the practice manager who told us that residential home patients were encouraged to attend the practice for an appointment if they were not housebound as it was good to have a change of environment. They told us they worked with the local residential homes to ensure appointments for long term condition reviews were booked in advance to make this possible.

The practice provided a service for all age and population groups. Registers were maintained of patients who had a learning disability, a long term condition or required palliative care. These patients were discussed at weekly clinical and monthly multidisciplinary meetings to ensure practitioners responded appropriately to the care needs of those patients.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. There was a hearing loop available for patients who had a hearing impairment and staff had access to telephone interpreters for any non-English speaking patients.

There was good disabled access to the building and all patient areas and consulting rooms were on the ground floor. Accessible toilet facilities were available for all patients and included baby changing facilities.

Access to the service

Information regarding the practice opening times and how to make appointments were available in the reception area, the practice leaflet and on the website. Patients could book appointments by telephone or in person at the reception. Some appointments were pre-bookable and some were allocated to be booked on the same day.

Home visits were offered for patients who needed it. We spoke with the practice manager who told us the practice were also respectful of non-housebound patients who sometimes found it difficult to attend the surgery for an appointment.

The practice offered a range of book on the day and pre-bookable appointments between 8.00am and 5.30pm Monday to Friday with the exception of alternate Wednesdays when the practice is closed for training.

When the practice was closed, urgent healthcare advice that was not a 999 emergency was provided by telephoning the Out of Hours NHS 111 service.

Results from the national patient survey (January 2015), demonstrated patients were happy with most aspects of the service. For example, 89% of respondents were able to get an appointment to see or speak to someone the last time they tried and 99% of respondents say the last appointment they got was convenient.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system both in the reception area, the practice complaints leaflet and on the website. The practice leaflet also sign posted patients to the complaints leaflet.

The patients we spoke with were aware of the process to follow if they wished to make a complaint.

Are services responsive to people's needs? (for example, to feedback?)

We looked at how complaints received by the practice in the last 12 months had been managed. The records showed complaints had been dealt with in line with the practice policy and in a timely way. Patients had received a response which detailed the outcomes of the investigations.

We saw evidence that actions and learning from complaints was discussed at practice meetings and were shared with staff.

Are services well-led?

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

Our findings

Vision and strategy

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

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's vision and values included supporting the population to achieve good health outcomes and delivering the best possible care.

Staff told us the practice vision and values were embedded within the culture of the practice. They told us the practice was patient focused; they spoke positively about the leadership and felt valued as employees.

Governance arrangements

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above CCG and National averages in all clinical domains.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and safeguarding within the practice. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out and where risks were identified, action plans had been produced and implemented.

Leadership, openness and transparency

The practice was committed to ongoing education, learning and individual and team development of staff. The performance of staff was the subject of monitoring and appraisal at all levels; which reflected the organisational objectives.

There was good communication between staff. The practice had a proactive approach to incident reporting. They discussed if anything, however minor, could have been done differently at the practice.

We were able to review a range of policies including confidentiality, information governance and complaints. These clearly outlined responsibilities and timescales.

Staff we spoke with told us all members of the management team were approachable, supportive and appreciative of their work. Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, the patient participation group (PPG) and comments cards. Patient survey results and action plans were available on the practice website.

We saw the practice had acted upon feedback from patients via the national survey and findings from the PPG. For example, we spoke with two members of the PPG who told us that concerns had been raised during a meeting regarding the attitude of a member of staff. They told us the practice manager and GP at the meeting had acknowledged this and as a result the issues were resolved.

The practice had gathered feedback from staff through meetings, appraisals and discussions. Staff told us they felt comfortable in giving feedback or raising any concerns. Staff told us they felt involved and engaged in the practice to improve outcomes for both patients and staff.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. They told us annual appraisals took place, which included a personal development plan. This was evidenced in the staff files we looked at.

Are services well-led?

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

The practice had completed reviews of significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients. We saw evidence of this in minutes of meetings and logs of events.