Dr GAM Burnett and Partners

Quality Report

Sonning Common Health Centre
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Date of inspection visit: 14/01/2015
Date of publication: 19/03/2015

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

We carried out an announced, comprehensive inspection on 14 January 2015.

We visited the practice location of Dr GAM Burnett and Partners at Sonning Common Health Centre, Wood Lane, Sonning Common, Reading, RG4 9SW. Overall the practice is rated as outstanding.

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, with the exception of those relating to the security and monitoring of fridge temperatures.
- 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 were being assessed.
- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- 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 several areas of outstanding practice including:

- The health promotion initiatives led by the practice to encourage patients to adopt healthy lifestyles, including 'Health Walks', 'Green Gym' (gardening and conservation project) and cycling club.

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- The practice's strong focus on creating a culture of education and learning was demonstrated through the four GP trainees in post, one trainee practice nurse and mentor scheme for salaried GPs.
- A nurse practitioner with advanced skills in administering joint injections provided this service to patients.
- A weekly transport service, via a local voluntary group was funded by the practice. This was available for patients resident in a nearby village, without their own transport for routine appointments, which the practice scheduled on Friday mornings.
- The practice had an effective and efficient leadership structure which included the use of an "away day" to develop future practice planning. All staff shared the practice objectives to deliver high quality person centred care. There was a very strong quality and educational ethos in the practice.

However there were areas of practice where the provider needs to make improvements.

The provider should

- Ensure the medicines management procedures are consistently followed by staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Medicines management policies and procedures were in place, however, we found improvements were required in relation to the security of the refrigerated vaccines and medicines and temperature recording system. Fridge temperatures were recorded daily, however, minimum and maximum fridge temperatures were not recorded and improvements were needed in the system for checking emergency drugs and equipment.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. For example, one of the nurse practitioners had advanced skills in administering joint injections. Health promotion for patients was a priority for the practice, demonstrated through a number of exercise initiatives offered by the practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for all aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group

Summary of findings

(CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. The practice provided a flexible appointment system which involved a duty GP, to ensure all patients who needed to be seen the same day were accommodated, including late evening and twice monthly Saturday morning surgeries. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

A weekly transport service, via a local voluntary group was funded by the practice. A dispensing service for patients who lived more than one mile from a pharmacy was provided and a prescription collection and delivery service.

Are services well-led?

Outstanding 

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice had a strong focus on education; staff had received inductions, regular performance reviews and attended staff meetings and training events.

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

Outstanding 

The practice is rated as outstanding 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.

Older people were a large part of the registered practice population. The practice considered the needs of older people in the provision of the service. For example, they had developed care plans for 153 out of 154 patients with complex needs, of which 66 were resident in a nursing home. The practice worked closely with a local nursing home to ensure patients received consistent care from a named GP. The practice promoted advance care planning for patients through workshops led by a GP. A weekly transport service, via a local voluntary group was funded by the practice. A dispensing service for patients who lived more than one mile from a pharmacy was provided and a prescription collection and delivery service.

People with long term conditions

Outstanding 

The practice is rated as outstanding for the care of patients with long-term conditions. 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 that 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. The majority of patients with long term conditions had received annual reviews of their condition: 94% of patients with diabetes, 89% of patients with chronic obstructive pulmonary disease (lung disease), 95% of patients with asthma and 97% patients with high blood pressure. Longer appointments and home visits were available when needed.

Families, children and young people

Good 

The practice is rated as good for the care of families, children and young people. For example, children and young people who had a high number of A&E attendances. Last year's performance for child

Summary of findings

immunisations was 89.7% at 12 months of age, 94.3% at 24 months and 96.5% at 5 years. Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. Appointments were available outside of school hours. The practice had a close working relationship with the co-located health visitors, which enabled them to raise concerns promptly when they arose.

Working age people (including those recently retired and students)

Outstanding 

The practice is rated as outstanding 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, for example early morning and late evening appointments were offered. The practice was proactive in providing online services as well as a full range of health promotion and screening that reflects the needs for this age group. For example, travel clinic, acupuncture and a physiotherapy service.

The practice had introduced fortnightly Saturday morning surgeries and a weekly late evening surgery for routine appointment to accommodate the needs of the working age people. The practice also offered the convenience of a daily phlebotomy service, well woman clinic, minor conditions managements and travel immunisations. Online repeat prescription and appointment bookings were also available. Health promotion initiatives including 'Healthwalks', 'Green Gym' (gardening project) and cycling clubs which were all aimed at adults to maintain healthy lifestyles.

People whose circumstances may make them vulnerable

Good 

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients 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

Summary of findings

safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours. A dispensing service for patients who lived more than one mile from a pharmacy was provided and a prescription collection and delivery service.

A follow up of bereaved patients was offered one year after their bereavement to assess their needs.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). Ninety one per cent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice was working towards the joint Oxfordshire dementia plan to increase awareness and improve identification of patients at risk of dementia. Eighty three patients with dementia had been identified thus far, as this was below the expected number for the practice, the GPs were reviewing all patients with a possible missed diagnosis of dementia. GPs worked with the community mental health team to reduce the demand for antipsychotic medication for patients in nursing homes.

The practice provided information about how to access appropriate groups and voluntary organisations.

It also provided an in-house counselling service and also referred patients to 'Talking Therapies'.

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What people who use the service say

The 2015 national GP patient survey results for Dr GAM Burnett and Partners based on 124 surveys (48%) responses, showed the practice was rated above the local average for all the measures. The practice scored significantly above average on satisfaction of patients obtaining appointments. This was confirmed by the 10 patients we spoke with on the day of inspection. All the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We received one completed comment card which was also positive.

Areas for improvement

Action the service SHOULD take to improve

Ensure the medicines management procedures are consistently followed by staff.

Outstanding practice

- The health promotion initiatives led by the practice to encourage patients to adopt healthy lifestyles, including 'Health Walks', 'Green Gym' (gardening and conservation project) and cycling club.
- The practice strong focus on creating a culture of education and learning was demonstrated through the four GP trainees in post, one trainee practice nurse and mentor scheme for salaried GPs.
- A nurse practitioner with advanced skills in administering joint injections provided this service to patients.
- A weekly transport service, via a local voluntary group was funded by the practice. This was available for patients resident in a nearby village, without their own transport for routine appointments, which the practice scheduled on Friday mornings.

The practice had an effective and efficient leadership structure which included the use of an "away day" to develop future practice planning. All staff shared the practice objectives to deliver high quality person centred care. There was a very strong quality and educational ethos in the practice.

Dr GAM Burnett and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP**.** The team included a CQC pharmacy inspector and a specialist in practice nursing.

Background to Dr GAM Burnett and Partners

Dr GAM Burnett and Partners, also known as Sonning Common Health Centre, is located in purpose built premises in a semi-rural area in Oxfordshire. It holds a primary medical services (PMS) contract to provide primary medical services to approximately 8 500 registered patients.

Care and treatment is delivered by four GP partners, four salaried GPs and four GP trainees, practice nurses, administration, reception staff, dispensary staff and two practice managers; a total of 39 staff. The practice dispenses prescriptions to approximately a third of its patients.

The practice has a higher proportion of patients over the age of 45 years compared to the local Oxfordshire Clinical Commissioning Group (CCG) and national average and a lower proportion in the 15-39 year age group. The practice serves a population which is significantly more affluent than the national average. The practice has been accredited to provide training to GP trainees.

The practice takes an active role within the Oxfordshire Clinical Commissioning Group (CCG). The senior partner is the CCG South East Locality Clinical Director and Urgent Care Lead.

The CQC intelligent monitoring did not provide a banding for the practice as it had been inspected previously in July 2014.

The practice has opted out of providing out-of-hours services to its own patients. There are arrangements in place for patients to access care from an out-of-hours provider, NHS 111.

We visited the practice location at Sonning Common Health Centre, Wood Lane, Sonning Common, Reading, RG4 9SW.

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 was 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.

This provider was inspected in July 2014 and we identified improvements were needed in relation to recruitment. We inspected the practice on 14 January 2015 to check whether improvements had been made.

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

Detailed findings

How we carried out this inspection

Prior to the inspection we contacted the Oxfordshire Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Dr GAM Burnett and Partners. We also spent time reviewing information that we hold about this practice including the action plan they provided following their previous inspection.

The inspection team carried out an announced visit on 14 January 2015. We spoke with 10 patients and 13 staff. We also reviewed one comment card from a patient who had shared their views and experiences.

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff interacted with patients and talked with them. We interviewed a range of practice staff including GPs, nursing staff, managers and administration and reception staff.

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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as 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. For example, we reviewed two incident reports relating to the way the practice handled urine samples from patients and the subsequent improvements made.

We reviewed safety records, incident reports and notes of meetings where these were discussed for the last 18 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 18 months and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every two months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw the system in place to track incidents to ensure they were monitored and managed in a timely manner. We reviewed the notes of the last two significant event meetings and saw that incidents which had not been discussed were carried over to the next meeting, planned for February 2015. At least 10 incidents were discussed at each meeting. We saw evidence of action taken as a result. For example, two incidents related to advance care planning which resulted in changes in the way the practice cared for people in the nursing home. Another incident led to the GPs writing in plain English to ensure reception staff were able to communicate the right message to patients, for example, in relation to test results. These had been discussed by the whole practice team and discussions recorded in the notes of the serious event meetings.

National patient safety alerts were disseminated by the practice manager to practice staff. Nursing staff we spoke with confirmed they received alerts and took the appropriate action.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. A designated GP was the practice lead for safeguarding children. Safeguarding policies and procedures consistent with the local clinical commissioning group (CCG) and Local Authority guidelines were in place to protect children and vulnerable adults. The practice child protection lead had carried out Royal College of General Practice audits on child protection in 2013 and 2014. These indicated the practice was compliant in most areas and the latter audit demonstrated an improvement from one year to the next as a result of actions taken.

Safeguarding information, including local authority contacts, were accessible on the practice intranet. Staff demonstrated an understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. All staff had received training in safeguarding children. All GPs had level three safeguarding children training. At the previous inspection we found there was a lack of staff training on safeguarding adults. The practice had recently provided staff with adult safeguarding training and had a named GP lead for adult safeguarding. Staff were able give examples of where they had raised concerns about patients' safety in and outside the practice.

There were chaperone notices at the reception desk and in all consulting rooms to prompt patients to request a chaperone if desired. The nurses, health care assistants and dispensing staff acted as chaperones if needed. They were all trained, aware of their responsibilities and had disclosure and barring service (DBS) checks in place.

Medicines management

At the previous inspection we found policies and procedures covering the supply of medicines were in place, however we found staff were not following the procedures consistently. The practice had reviewed its procedures and

improvements had been made in the way repeat prescriptions were generated by practice staff. We found these were now always signed by a doctor before dispensing in line with legislation.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We observed one of the fridges was unlocked and stored in an unlocked room, potentially accessible to patients. We raised this with staff and they responded by planning a risk assessment of the situation. The practice had appropriate medicines refrigerators which they monitored the temperatures on a daily basis. However, minimum and maximum temperatures were not recorded, hence the safe efficacy of vaccines could not be fully assured.

Processes were in place to check medicines were within their expiry date and suitable for use in the dispensary. All the medicines we checked were within their expiry dates, except for one of the emergency drugs and one set of defibrillator pads. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistants administered vaccines using patient group directions and patient specific directions respectively; these had been produced in line with legal requirements and national guidance. Two of the nursing staff were qualified as independent prescribers and they received regular supervision and support in their role from one of the GPs. They also attended update training in the specific clinical areas of expertise for which they prescribed, for example, diabetes.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for people to pick up their dispensed prescriptions at a different location. However, a robust system to monitor how these medicines were collected was not in place.

Cleanliness and infection control

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

Systems were in place to reduce the risks of spread of infection. A designated member of staff was the practice infection control lead person. They demonstrated a good understanding of their role. All staff had received training in infection control and were aware of infection control practices. For example, we observed staff used personal protective equipment such as gloves and saw that they disposed of clinical waste safely. The practice had recently made changes in the way they received samples from patients following two recent incidents.

In June 2014 the practice had commissioned an external contractor to assure itself of compliance in infection prevention and control. We reviewed the results of the infection control audit carried out in June 2014. It highlighted a number of areas that had been identified for improvement. A Legionella risk assessment had been carried out and a re-audit was planned in June 2015.

All the patients we spoke with said they had never had any concerns regarding the standard of cleanliness at the practice. We observed all areas of the practice were clean and well maintained. Daily cleaning schedules were followed and monitored. We saw evidence that when issues were identified they were raised with the contractor.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments

and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors.

Regular checks on the premises and equipment were in place to ensure they were fit to use. For example, service checks on gas, electricity and fire equipment were all up to date.

Medical equipment, including medicines, a defibrillator and oxygen were available for use in the event of a medical emergency. The equipment and medicines were checked monthly to ensure they were fit for use. However, at the time of the visit we found the spare set of defibrillator pads were out of date by over one year. One emergency medicine had also expired two weeks earlier, although we were told it had not been replaced as there was a supply problem with this particular medicine. All staff had training in basic life support and defibrillator training to enable them to respond appropriately in an emergency.

Staffing and recruitment

Records we looked at contained evidence that 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 of staff 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.

The majority of practice staff worked part time which allowed for some flexibility in the way the practice was managed. For example, staff were available to work overtime if needed and available for annual leave and sickness absence cover. A bank of regular GP locums was used to ensure familiarity with practice procedures and a degree of continuity of care for patients.

There were recruitment and selection processes in place. Staff described the recruitment process which followed best practice guidelines. We reviewed a sample of six files which confirmed the required pre-employment information had been sought. These included all the required information including a curriculum vitae or application form, one or two references, occupational health check, photographic identity and professional registration check. The practice did not have a system in place to carry out annual checks of up to date professional registration. All staff working at the practice had a Disclosure and Barring Service check in place. The practice had improved the arrangements for checking the hepatitis B status of staff; up to date records were now available which demonstrated staff were protected from the occupational exposure to this infection.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place 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, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that issues and risks were discussed at GP partners' meetings and within team meetings. For example, following a recent security incident a practice wide risk assessment was carried out and a staff survey on security. The findings and recommendations were discussed at the partners' meetings and actions implemented including new door locks.

The practice had considered the risks of delivering the service to patients and staff and had implemented systems to reduce risks. We observed the practice was organised and tidy. We reviewed the practice fire risk assessment and noted safety equipment such as fire extinguishers were checked and sited appropriately.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. However, at the time of the visit we found the spare set of defibrillator pads were out of date.

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. For example, contact details of a heating company to contact if the heating system failed.

Outstanding ☆

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 saw notes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as minor surgery, allergy and rheumatology and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines as part of their daily meetings and in their weekly clinical meetings.

We reviewed prescribing data from the local clinical commissioning group (CCG) which showed Sonning Common Health Centre's performance compared favourably with other practices for prescribing antibiotics and anti-inflammatory drugs. The GPs had reviewed their own patients to identify those with complex needs. Of 154 patients identified, 153 patients had care plans in place and 66 of those were patients in a nursing home.

CCG data showed the practice was in the middle or lower range of referrals for all major specialities except for orthopaedics and ophthalmology. The practice regularly reviewed referrals to these two specialities to ensure they were appropriate. GP trainees presented evidence to their GP trainer to support their clinical decisions for referrals. This resulted in a culture of learning and constructive challenge where clinical decisions were considered in the light of evidence based practice and experience.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us eight clinical audits that had been undertaken in the previous 12 months. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. A wide range of clinical audits in a rolling audit programme had been undertaken which showed practice was measured against current best evidence and demonstrated adherence to current guidelines. To monitor changes in practice and outcomes for patients. For example, an audit of inadequate smears by all smear takers in the practice made recommendations including observational training for those practitioners who had a high rate of inadequate smear results. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance. Clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of high risk drugs which required regular blood tests to monitor patient safety and effectiveness.

The practice achieved 99.5% of the maximum Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain and was expecting similar results for 2014/15. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice maintained and managed patients with a range of long term conditions in line with best evidence based practice.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The majority of patients with long term conditions had received annual reviews of their condition in the previous year; overall QOF achievement for the following long term conditions was approximately 4% higher than the CCG average between 2.8% to 9.6% above the national average: 99.7% for diabetes, 100% for chronic obstructive pulmonary disease (lung disease) and 100% for asthma. This year (2014/15) the practice was on track to meet or exceed the previous year's achievement. The practice had identified 83 patients with dementia thus far. The practice recognised this figure was below the expected number for Sonning Common Health Centre, in response one of the GPs was in the process of reviewing those patients who may have not been originally identified to ensure all patients received appropriate care and intervention. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance and support their GPs and nursing staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement; this was facilitated by daily 'coffee morning' meetings and formal weekly clinical meetings.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw an example of an audit carried out as a result of a new alert of a potential drug interaction to review all patients prescribed the drug and ensure safe and effective prescribing. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The practice manager was in the process of undergoing a training needs analysis for all staff. To support this, a new payroll and human resource IT system had been installed and was being rolled out. However, up to date staff training records for all staff were not readily available at the time of the visit. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a trainee nurse had recently been appointed. One member of the nursing staff had received support to enable her to undertake a degree. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with. Salaried GPs praised the mentor scheme provided by the practice and GP partners took advantage of the two month sabbatical offered to them every eight years.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example diabetes and asthma were also able to demonstrate that they had appropriate training to fulfil these roles. One of the nurse practitioners had advanced skills in administering joint injections. She attended clinical updates with the GPs and had close links with the local specialist hospital nurses to ensure she had the necessary skills and support to provide this treatment to patients.

New staff followed an induction programme and probationary period, followed by a formal review. This ensured staff were familiar with practice procedures and competent to perform their duties.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received

blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in 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 was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held monthly multidisciplinary team meetings every two meetings to discuss the needs of complex patients, for example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Multidisciplinary meetings which included members of the palliative care team and community nursing team were held every two months. Discussion of palliative care patients followed the Gold Standards Framework for end of life care. The Gold Standards Framework is a systematic evidence based approach. It is designed to assist healthcare professionals to optimise care for all patients approaching the end of life.

The practice operated a GP buddy system which ensured all correspondence and results were managed in a timely manner to optimise patient care. The GP buddy system ensured all essential duties, for example, checking test results and signing prescriptions were completed when a GP was on leave.

Information sharing

The practice used several 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. Electronic systems were also in place for making referrals, the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice website included its statement of intent regarding electronic patient records. The practice has signed up to the electronic Summary Care Record and offered patients access to their electronic GP record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that GPs were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed. One of the GPs told us they involved patients and families in discussions before completion of the do not attempt cardiopulmonary resuscitation form.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed every three months (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All those patients had a care plan in place. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff

demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had been followed in 100% of cases.

Health promotion and prevention

The practice was aware of the local area health priorities and more specifically in relation to their practice population. The practice had a strong history of health promotion through education and facilitating exercise.

It was practice policy to offer a health check with the health care assistant / practice nurse 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. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 95 patients in this age group took up the offer of the health check in the previous three months. A GP told us how patients were followed up promptly if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 13 out of 23 patients had an annual review of their condition so far this year. The practice had also identified the smoking status of 88% of patients over the age of 16 and 98% had been offered smoking cessation advice.

The practice's performance for cervical smear uptake was 83%, which was above average for the CCG area. Patients who did not attend for screening were followed up by the practice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations was 89.7% at 12 months of age, 94.3% at 24 months and 96.5% at 5 years. The practice had a clear policy for following up non-attenders by the GP.

A range of information was available in the reception area and on the practice website, aimed at patients for health promotion and self-care. A detailed practice booklet which described a number of health promotion initiatives including 'Health Walks', 'Green Gym' (gardening and conservation project) and cycling club. 'Health Walks' had been pioneered by a founding partner of the practice and had developed nationally and internationally. It was now a well-known scheme, similarly the Green Gym. The practice focus on encouraging and actively supporting patients to adopt exercise had continued with other initiatives including a cycling club led by the Senior GP Partner. The practice is one of the sponsors of an annual local cycling event which attracted over 500 riders in the 2014 event.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. The 2015 national GP survey indicated very good satisfaction. The practice achieved above the clinical commissioning group (CCG) average in all questions and a good response rate of 124 completed surveys (48% response). For example, 99% of respondents rated their overall experience of the surgery as good and 95% would recommend the surgery. Its satisfaction scores on consultations involving care and concern with doctors and nurses was 95% and 99% respectively and 99% patients said both GPs and nurses were good at listening.

We spoke with 10 patients during the inspection and received one comment card. The 10 patients consisted of eight older patients. Nine patients had been with the practice 20 to 30 years and were able to recount many experiences of their own and with their growing families. We also spoke with a representative of the patient participation group (PPG). All the patients we spoke with were extremely positive about all aspects of the service they received. They told us reception staff were always helpful and accommodating with regards to appointments and GPs and nurses provided compassionate care.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The waiting area was located away from the practice reception desk, this helped patient confidentiality. We discussed this with the practice as we observed patients were not under the supervision of reception staff whilst in the waiting area. However, staff told us GPs and nurses frequently surveyed the waiting area each time they personally called patients for their appointments and this arrangement was effective.

All staff had received training on information governance and signed a confidentiality agreement at the start of their employment. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, during the inspection we witnessed numerous caring and compassionate interactions between staff and patients which demonstrated how staff treated patients with dignity and respect.

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 well in these areas. For example, data from the national patient survey showed 90% of practice respondents said the GP was good at involving them in decisions about their care and 98% said GPs were good at explaining tests and treatment, compared to 96% and 100% for nurses, respectively. Both these results were above average compared to the CCG area.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. However, staff confirmed the facility was very rarely used as the majority of patients could speak English.

Patients preferred methods of communication was recorded and the practice sought the patients consent before messages were left on answerphones.

GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed. One of the GPs told us they involved patients and families in discussions before completion of the do not attempt cardiopulmonary resuscitation form.

Good

Are services caring?

The practice was actively informing patients and the local community about advance care planning. The recent edition of the practice newsletter offered workshops in advance care planning led by one of the GPs.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection indicated patients were very positive about the emotional support provided by the practice. Bereaved patients were contacted by their named GP to offer support. An annual reminder was also sent to staff to ensure appropriate sensitivity if a relative attended the practice around the time of the anniversary of the bereavement.

Patients we spoke with who had suffered bereavement or had complex needs told they were provided emotional support to help them cope with their treatment.

Notices in the patient waiting room and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to 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.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We reviewed the PPG report 2013/14 following the PPG survey. The majority of feedback was positive. Suggestions included improvements for patients when contacting the practice. An action plan had been developed and actions completed. For example, a text message reminder service had been introduced.

The practice had developed its services to meet the needs of its registered practice population. For example, a family planning clinic was available in the evenings to accommodate the needs of young people.

The practice provided specific medicines to patients at the end of life in advance of when they may need them. This was to avoid undue distress to patients and relatives by reducing delays in obtaining medicines out-of-hours.

The results of the patient participation group (PPG) survey 2014 indicated patients were very positive about the care they received. The few negative comments were in relation to contacting the practice and the car park facilities. An action plan to address the issues raised in the questionnaire had been developed although clear deadlines had not been set for when actions were to be completed by.

Tackling inequity and promoting equality

The practice has a higher proportion of patients over the age of 45 years compared to the local Oxfordshire Clinical Commissioning Group (CCG) and national average and a lower proportion in the 15-39 year age group. The practice serves a population which is significantly more affluent than the national average. Life expectancy for males and females is higher than the national average. The practice population of patients identified from non-white ethnic groups is less than 1%.

The practice had access to online and telephone translation services. However, staff confirmed the facility was very rarely used as the majority of patients could speak English.

The practice maintained a register of all patients with a learning disability. One hundred per cent of patients on the register had annual reviews of their condition in 2013/14 and 13 out of 23 patients had an annual review of their condition so far this year.

The patient areas of the practice were all located on the ground floor of the premises. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8.10am to 6pm daily. Extended surgery hours were provided by a mid-week late night surgery, up to 8.30pm and twice monthly Saturday morning surgery for routine appointments. This access was particularly useful to patients with work commitments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. For example, we saw an alert on a record of a patient who suffered breathing difficulties, to book 20 minute appointments to allow for the extra time this patient needed. Weekly visits were made to one nursing home by a named GP.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

on the same day of contacting the practice. On the day we visited, patients told us they were able to obtain urgent and routine appointments when needed and our review of the appointment system record confirmed this.

The practice operated a flexible appointment system which involved a duty GP, to ensure all patients who needed to be seen the same day were accommodated. A weekly transport service, via a local voluntary group was funded by the practice. This was available for patients resident in a nearby village, without their own transport for routine appointments, which the practice scheduled on Friday mornings. Annual flu clinics were scheduled on Saturdays to increase the attendance of patients who were eligible for the flu vaccination. The practice offered a dispensing service for patients who lived more than one mile from a pharmacy and a repeat request drop off point at a nearby village post office for patients who did not use the online service.

Data from the national patient survey showed the practice was significantly better in all areas but particularly in relation to access to appointments: 93% of respondents described their experience of making an appointment as good , compared to the local average of 80%. Ninety per cent of respondents were satisfied with the surgery's opening hours compared with the local average of 77%.

A private physiotherapy service was available to patients on site.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its 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 that information was available to help patients understand the complaints system in the practice leaflet and website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received in the last six months and found they were satisfactorily handled and dealt with in a timely way. The practice showed openness and transparency in dealing with the compliant. Three complaints had been reviewed at the 'significant event meetings' and learning shared. No complaint had been escalated to the Ombudsman.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The senior GP had a vision for the practice, although it was not written in a business plan or strategy. We spoke with 13 members of staff and they all told us they aimed to provide high quality care and promote good outcomes for patients. All staff shared the practice objectives to deliver high quality person centred care. The practice website included the practice aim to 'help develop a healthy community' through a strong focus on health promotion. The practice engaged with the local community to encourage healthy living.

The practice held occasional 'away days' and the next one was planned for February 2015 to develop the practice development plan and to review the appointment system.

The partners modelled behaviours to encourage a culture of openness and transparency which permeated throughout the practice. There was a very strong quality and educational ethos in the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All eight policies and procedures we looked were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, the senior partner was the lead for safeguarding adults and there was a lead nurse for infection control. Other partners had lead roles in finance, training, child protection and prescribing. We spoke with 13 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 used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit of inadequate smears by all smear takers in the practice made recommendations including observational training for those practitioners who had a high rate of inadequate smear results.

The practice had carried out a range of risk assessments reviewing environmental and personal risks, to ensure the health and safety of patients, visitors and staff members. The practice had a service continuity plan in place in case of emergency. Relevant contact numbers for staff and resources were recorded in the plan. These were to be used in the event of an incident that effected the operation of the service to ensure, where possible, alternative provision could be made and patients were appropriately informed.

The practice had arrangements for identifying, recording and managing risks. We saw risks were regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, following a recent security incident a practice wide risk assessment was carried out and a staff survey on security. The findings and recommendations were discussed at the partners' meetings and team meetings.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Arrangements were in place to ensure staff were clear about their responsibilities and were familiar with practice procedures. An annual practice meeting schedule was in place which covered administration meetings, clinical meetings and business meetings. The meetings supported staff and ensured they were kept up to date with changes to practice systems. Staff told us they were comfortable to raise issues and concerns when they arose and were confident they would be dealt with constructively.

Every morning a clinical meeting was held which GPs and nurses told us they found very valuable in discussing day to day clinical issues and obtaining support from colleagues.

The practice had a system to ensure actions were taken in a timely manner. For example, a colour coded message alert system was used so that GPs could easily prioritise messages during busy clinics. The practice operated a

Are services well-led?

Outstanding ☆

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

buddy system for GPs and nurses to ensure suitable cover was provided when their buddy colleague was on leave. This included checking correspondence and test results. Unchecked test results were highlighted on the screen and could only be closed when a GP had reviewed the result and recorded the action to be taken.

The practice regularly reviewed its policies and procedures and implemented changes as a result of learning from serious events.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice management team were responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment, confidentiality and whistleblowing, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

All staff spoke about a desire to provide high quality, patient centred care. The practice benefited from dedicated long serving staff. Staff described a supportive and inclusive environment where individual roles were valued. The GPs in the practice emphasised a strong focus on education and learning for all staff and for patients to be supported to adopt healthy lifestyles.

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

The practice valued the role of their patient participation group (PPG) and meetings were attended by one of the GP partners. The PPG is a forum for patients of the practice to share their experience and engage in improving the service for all patients. The Sonning Common Health Centre PPG consisted of 25 members. They were all patients of the practice and were actively involved in the practice. The PPG was made up of mainly older patients. However, they were active in trying to recruit younger and working age patients. They scheduled evening meetings to encourage attendance of these groups of patients. This was supplemented by an extended virtual group forum. We reviewed the PPG report 2013/14 following the PPG survey. We were told the survey response was significantly higher than in previous years due to the wide dissemination of the surveys and the option of paper and online completion. The majority of feedback was positive. Suggestions included improvements for patients when contacting the practice. An action plan had been developed and actions completed. For example, a text message reminder service had been introduced.

The practice engaged with staff informally and formally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff gave examples of when they had raised concerns if they felt it necessary. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the policy.

Staff told us they felt valued as part of the practice team. There were opportunities for formal and informal communication for staff, to ensure issues were raised and managed appropriately. An annual meeting schedule was in place which included significant event meetings, clinical meetings and practice business meetings. The practice nominated a senior partner who was the designated lead for staff matters and formally responsible for dealing with staff concerns or issues. The practice welcomed feedback from the public, via a contact form on the practice website, a suggestion box in the reception area and the NHS choices website. The practice had recently introduced the NHS Friends and Family test.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

All the GPs mentioned the practice's focus on education. GP trainees were expected to present an evidence base to support treatment and referral decisions to their GP trainer. Staff said they had opportunities for development. All staff had been appraised in the last year. Staff told us they felt

Are services well-led?

Outstanding ☆

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

the appraisal was a meaningful process and identified areas for future personal development. The practice manager was in the process of undergoing a training needs analysis for all staff. To support this, a new payroll and human resource IT system had been installed and was being rolled out. However, up to date staff training records for all staff were not readily available at the time of the visit.

The practice had completed reviews of significant events and other incidents and shared with staff at team meetings to ensure the practice improved outcomes for patients.

We saw the recent re-approval report from the local Deanery. It highlighted the 'Broad range of clinical and educational expertise' at the practice. The practice commitment to creating a learning environment to foster high achievement for all staff was demonstrated by the protected time scheduled for trainers for education and the recent appointment of a trainee practice nurse.