Falkland Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Falkland Surgery on 23 June 2015.

Overall the practice is rated as good.

The overall rating for this service is good. We found the practice to be good for delivering safe, effective, caring, responsive services and for being well-led. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

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.
- 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.
- The practice engaged effectively with other services to ensure continuity of care for patients.
- The practice understood the needs of the local population and planned services to meet those needs.
- 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.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place,

Summary of findings

was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

- 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 areas of outstanding practice:

- The practice was involved in research development to help support best clinical practice. For example, the practice led a pioneering scheme to identify patients who were identified as high risk and had a likelihood of developing diabetes within the next 20 to 30 years. A practice GP designed and implemented the project and diabetes tool to improve detection of diabetes among 100,000 patients in the local Clinical Commissioning Group for which they won an award.
- The practice worked with the patient participation group (PPG) to organise patient education meetings. These were held at the practice and were open to any patient who wished to attend. Recent topics covered included; resuscitation, first aid, heart disease and men's health. We were told these education meetings were very well attended.

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. The practice had a system in place for reporting, recording and monitoring significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated widely to support improvement.

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. However, the practice had not systematically reviewed or rehearsed evacuation plans in the event of a fire. There were enough staff to keep patients safe.

The practice had suitable equipment to diagnose and treat patients and medicines were stored and handled safely.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Quality and Outcomes Framework (QOF) data available to us showed that the practice had higher than National and local average achievement levels.

We looked at the QOF data for this practice which showed at 99.5%, the practice was performing above Newbury and District Clinical Commissioning Group average of 93.9% and above the national average of 94.2%.

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 several aspects of care. Patients told us they were treated with

Summary of findings

compassion, dignity and respect. They described staff as being friendly, caring and helpful. This was reflected in the data we looked at which showed positive patient feedback in relation to involvement in decisions about their care and treatment. The practice had good systems in place to support carers and patients to cope emotionally with their health and condition. Information to help patients understand the services available was easy to understand.

Support was available at the practice and externally for those suffering bereavement or that had caring responsibilities for others.

We saw that staff were respectful and polite when dealing with patients, and maintained confidentiality.

Views of external stakeholders such as care home managers were positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. 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. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on.

There was a high level of constructive engagement with staff and a high level of staff satisfaction. The patient participation group (PPG)

Summary of findings

was active. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care. Staff had received inductions, regular performance reviews and attended staff meetings and 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

Good

The practice is rated as good for the care of older people. Every patient over the age of 75 years had a named GP. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice employed two Assistant Care Co-ordinators to support patients over 75 with care plans. 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.

Unplanned hospital admissions and readmissions for this group were regularly reviewed and improvements made.

It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice identified if patients were also carers; information about support groups was available in the waiting room.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. We found that the nursing staff had the knowledge, skills and competency to respond to the needs of patients with long term conditions such as diabetes and asthma. Longer appointments and home visits were available when needed. All of these patients were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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.

Childhood immunisation rates for the vaccinations given in 2014/15 were good for all standard childhood immunisations. Immunisation rates for under two year olds ranged from 90% to 97.6% and five year olds from 92.3% to 98.5%. These were above local and national averages.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we

Summary of findings

saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We heard about examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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.

There was morning (07:30-08:00) and evening (18:30-19:00) phone consultation service for patients. The practice opened on alternate Saturdays and provided pre-bookable appointments between 08:30-11:30 which was particularly useful to patients in this group.

The practice was offering comprehensive online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 those with a learning disability. It had carried out annual health checks for patients with a learning disability. Longer appointments were available to patients where needed, for example when a carer was required to attend with a patient.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Patients receiving palliative care were supported by regular multidisciplinary team reviews of their care needs.

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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety five 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. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 13 patients visiting the practice and we received 16 comment cards from patients who visited the practice in the two weeks prior to inspection. We spoke with patients from various groups including mothers and fathers with young children, working age people, older people and people with long term conditions.

We looked at the practices' NHS Choices website to review comments made by patients. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey.

We reviewed the results from the latest National GP Patient Survey (published in January 2015) and found the responses confirmed the experiences we heard from patients. There were 260 surveys sent out, 122 returned giving a completion rate of 47%. The survey found the proportion of patients who would recommend their GP surgery was 70% which was 10% below the average for Newbury and District Clinical Commissioning Group (CCG). 98% had confidence and trust in the last GP they saw or spoke with which was above the CCG average of 95% and 73% of respondents say their experience of the service was good or very good.

The GP Patient Survey found 58% of respondents find it easy to get through to the surgery on the phone, which was significantly lower than the CCG average.

We also considered evidence from the feedback we received on the day from 16 completed CQC comment cards. Patients told us they were satisfied with how they were treated and that this was with compassion, dignity and respect. They told us that long term health conditions were well monitored and supported. The patients we spoke with in the day of inspection confirmed this. They also explained how they felt listened to and understood their treatment and care.

Outstanding practice

- The practice was involved in research development to help support best clinical practice. For example, the practice led a pioneering scheme to identify patients who were identified as high risk and had a likelihood of developing diabetes within the next 20 to 30 years. A practice GP designed and implemented the project and diabetes tool to improve detection of diabetes among 100,000 patients in the local Clinical Commissioning Group for which they won an award.
- The practice worked with the PPG to organise patient education meetings. These were held at the practice and were open to any patient who wished to attend. Recent topics covered included; resuscitation, first aid, heart disease and men's health. We were told these education meetings were very well attended.

Falkland Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included two specialist advisors (a GP and a Practice Manager) and an Expert by Experience.

Experts by experience are members of the team who have received care and experienced treatment from similar services. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Falkland Surgery

Falkland Surgery is a purpose built GP practice built in 2003 on the southern edge of Newbury town. Falkland Surgery is one of twelve practices within Newbury and District Clinical Commissioning Group.

The practice has core opening hours from 8:00am to 6:30pm Monday to Friday to enable patients to contact the practice. There was also a morning (07:30-08:00) and evening (18:30-19:00) phone consultation service for patients. The practice opened on alternate Saturdays when it provided pre-bookable appointments between 08:30-11:30.

Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for the doctors and for the nursing clinics. The practice treats patients of all ages and provides a range of medical services.

There are 14,340 patients registered with the practice. The practice population has a higher proportion of patients aged 40-65 compared to the national average. There is minimal deprivation according to national data. The prevalence of patients with a long term health problem is 60% compared to the national average of 54%.

Care and treatment is delivered by eight GP partners, one nurse prescriber, five practice nurses, one health care assistant, a practice manager, a deputy practice manager and a team of administration staff. There are four male GPs and four female GPs.

The practice is a training practice for GP Registrars. GP Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine.

The practice has a General Medical Services (GMS) contract. GMS contracts are nationally agreed between the General Medical Council and NHS England.

The practice opted out of providing the out-of-hours service. Westcall provides out of hours cover and this service is accessed via the NHS 111 service. Advice on how to access the out-of-hours service is clearly displayed on the practice website and over the telephone when the surgery is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act 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.

Detailed findings

How we carried out this inspection

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 were 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)

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from Newbury and District Clinical Commissioning Group (CCG), local Healthwatch, NHS England and Public Health England.

We carried out an announced inspection on 23 June 2015.

During the inspection we spoke with four GPs, one nurse, members of the management team, four members of the patient participation group, and three members of the administration and reception team.

We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to.

We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

We obtained patient feedback from speaking with patients, CQC patient comment cards, the practice's surveys and the GP national survey.

We observed interaction between staff and patients in the waiting room.

We asked two local care homes and the school which the practice served about the service they received from the practice. They told us the practice was very responsive to patients needs and treated them with dignity and respect.

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. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they may have and were able to explain and demonstrate the process in place.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently and could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of seven significant events that had occurred during the last year and saw the system was followed appropriately. When staff members reported a significant event it fed through to the agenda on the next clinical and significant meeting. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints.

There was evidence that the practice had learnt 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.

Records of significant events and complaints were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us.

For example, one significant event recorded had highlighted miscommunication between the practice and a patient who requiring an early pregnancy scan. The practice had reviewed their protocol for ensuring more effective communication in such circumstances.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. One member of staff told us about a safety alert in December 2014 resulting in a recall of insulin pens. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles.

All of the staff we spoke with knew who the practice safeguarding lead was and who to speak to if they had a safeguarding concern.

Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

Some staff we spoke with described recent incidents in which they had reported safeguarding concerns to the safeguarding lead or external services. Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

There was a system to highlight vulnerable patients on the patient electronic record. This included information to ensure staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments. For example, children subject to child protection plans.

There was a chaperone policy which was visible in the waiting room and on the doors of consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). One of the GP partners told us

that only clinical staff carried out chaperone duties and they had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines kept in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring medicines were kept at the required temperatures. We reviewed records which confirmed this. The correct process was understood and followed by the practice staff and they were aware of the action to take in the event of a potential fridge failure. The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked at the time of inspection were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of patient directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received regular support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

The practice implemented a comprehensive protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Reviews were undertaken for patients on repeat medicines.

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 and kept securely at all times.

Cleanliness and infection control

We observed the premises to be 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. The practice had a lead for infection control to enable them to provide advice on the practice infection control policy and carry out staff training. The practice trained its staff on infection control by ensuring all staff had read the infection control policy and any updates from latest guidance were sent to relevant staff for review. We saw evidence that the Infection Control Lead had carried out an infection control audit in March 2015. Minutes of practice meetings showed that the findings of the audit were discussed. The practice had a plan to re-audit in six months.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, during intimate or personal examinations. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had completed a risk assessment in May 2015 to assess the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that showed a risk assessment had been completed in 2015 and regular checks were carried out in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had enough 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 which was November 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, electrocardiogram and blood pressure measuring devices. The practice used single use items for patient examinations and these were disposed of in line with practice policies.

Staffing and recruitment

Staff files and records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to the employment of staff. For example, proof of identification, references, qualifications, previous experience and registration with the appropriate professional body. Criminal records checks were made through the Disclosure and Barring Service (DBS) for all clinical staff

The practice had an appropriate 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. A process was in place to manage staff absences.

Staff told us there were usually enough staff to maintain the smooth running of the practice and to keep patients safe. They provided cover for each other during annual leave or sick leave. The practice used four part-time long term locum GPs providing availability for patients when required.

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 regular 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 observed the practice environment was organised and tidy. Safety equipment such as fire extinguishers and the defibrillator were checked regularly and sited appropriately.

The practice had considered risks of delivering services to patients and staff and had implemented systems to reduce risks. We reviewed the risk assessments and identified risks. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions and those with complex needs there were processes to ensure these patients were seen in a timely manner. Staff told us that these patients could be urgently referred to a GP and offered longer appointments when necessary.

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 (AED) (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. We checked that the pads for the automated external defibrillator were within their expiry date.

The practice had carried out a formal risk assessment to determine the use of having an AED in reflection of the Resuscitation Council (UK) guidance for primary care, equipment and emergency medicines lists for cardiopulmonary resuscitation.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety.

Good

Are services safe?

Records showed that staff were up to date with fire training and the fire alarm system was serviced annually. The practice had carried out a rehearsal of their fire evacuation procedures in November 2013.

Processes were 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. For example, contact details of utility companies to contact if the heating, lighting or water systems failed.

Good

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 discussed with the practice manager, GPs and one of the nurses how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required.

We noted a good skill mix among the doctors with a number having additional qualifications and special interests. For example, one GP had a post-graduate palliative care certificate; another GP was the IT lead for the CCG and another GP had a special interest in women's health. Several GPs at the practice had post-graduate certificates in diabetes care and one GP was a volunteer speaker for a national diabetes charity.

The GPs told us they led in specialist clinical areas and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Two GPs performed minor surgery at the practice. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, the management of prescribing insulin to patients. Our review of the clinical meeting minutes confirmed that this happened.

The practice had a system to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Discussions with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

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 medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice used the information collected for the Quality Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF incentive scheme rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We saw there was a robust system in place to frequently review QOF data and recall patients when needed. The practice used the electronic system to alert clinical staff to collect QOF data when patients attended for a consultation or a home visit was carried out.

The practice achieved 99.5% QOF points out a possible 100%, which was above the National and local average. The practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

Information about patient 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. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. Staff spoke positively about the culture in the practice around quality improvement.

Good

Are services effective?

(for example, treatment is effective)

The practice had a system in place for completing a wide range of completed clinical audit cycles. These included audits for prescribing, minor operations, diabetes, safeguarding, COPD and osteoporosis.

The practice showed us nine clinical audits that had been undertaken in the last six months. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF).

We saw a current clinical audit regarding the practice prescribing antibiotics in relation to inflammation of the ear canal. The results showed that the practice were high prescribers of antibiotics, in comparison to national average and national guidance was not always followed when treating this condition. The results were shared with all GPs via email and were discussed at a clinical meeting. The practice had changed their protocols and updated guidance and as a result further auditing demonstrated that prescribing of antibiotics had dropped from 14% to 7.5%.

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 meetings as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice described and presented evidence of complimentary feedback from the family of a palliative care patient.

The practice also received information from the CCG, who ran quality data reports which were discussed at practice meetings, for example prescribing data. This information was used to review staff practice and make appropriate changes. 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.

Effective staffing

Practice staff included GPs, nurses, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended safeguarding vulnerable adults training and basic life support. We saw evidence that staff had received other mandatory training such as information governance, infection control and health and safety which were relevant to their roles.

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 which identified learning needs from which action plans were documented. We saw records in staff files of appraisals completed within the last twelve months and were shown a schedule of planned appraisals. Not all the appraisals we saw were signed but staff confirmed they had taken place and were a true recording of the meeting. Staff we spoke with confirmed that the practice was supportive in providing training and funding for relevant courses. For example, one of the staff we spoke with said they had asked for further training on chronic heart disease and had recently received confirmation that this training would be provided.

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. There was one trainee GP currently working at the practice and another planned to start in July 2015.

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, smoking cessation and cervical cytology. Those with extended roles for treating patients with conditions such as asthma, COPD or leg ulcers were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff we spoke with told us that the practice provided opportunities for learning and that they undertook a range of online and face-to-face training. All new staff underwent a period of induction to the practice. Support was available to all new staff to help them settle into their role and to familiarise themselves with relevant policies, procedures and practices.

We were shown the induction policy and an example of a comprehensive induction programme which had been completed in April 2015.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. 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 using these communications. We saw that all staff had completed information governance training which outlines the responsibilities to comply with the requirements of Data Protection Act 1998.

There was evidence that the practice worked closely with other organisations and health care professionals. We saw that the GPs had regular multidisciplinary meetings with representatives from the community nursing team, mental health services and adult social care to discuss the needs of patients with mental health problems.

The practice provided a designated room for the community nursing team attached to the practice. The community nursing team were able to liaise directly, either via the computer system or through one to one meetings, with the GPs and nursing team.

The practice told us they had established a good working relationship with two local care homes. We spoke with managers from the each of the care homes who told us that the practice provided a good service which was effective in meeting resident's needs.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. Staff we spoke with knew how to use the system and said that it worked well. One of the practice GPs currently ran the National User Group mailing list for the computer system in use and was leading a project allowing GP records to be viewed across other secure healthcare environments. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Systems were in place for making referrals through the NHS e-Referral Service, which replaced Choose and Book system in June 2015. This system enables patients to choose which hospital they wished to be seen in and book their own outpatient appointments in discussion with their chosen hospital.

The practice had signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). There was information on the practice website which gave further explanation and a statement of intent with reference to electronic patient records including information to opt out of Summary Care Record.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw that hard copies of letters and other information were scanned onto the system on the day they were received and forwarded to the GP for action. Staff told us that they were up to date with scanning, coding and follow up of electronic patient information.

Consent to care and treatment

We found that staff was aware of the Mental Capacity Act 2005 and the Children Acts 2004. All staff we spoke with were conscious of their duties in fulfilling both acts. The GPs and practice nurse we spoke with understood the key parts of the legislation and described how they implemented it in their practice.

During our discussions 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. The GPs and practice nurses demonstrated a clear understanding of the Gillick competency test. The lead GP demonstrated a comprehensive understanding of Gillick competency. (These were used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for recording 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 discussion about the relevant risks, benefits and possible

complications of the procedure. One of the GPs fits contraceptive implants uses the same consent process. Verbal consent was taken from patients for routine examinations.

Patients with learning disabilities 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 annually or more frequently if changes in clinical circumstances dictated it. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Health promotion and prevention

The practice followed guidance and local initiatives set by the CCG to meet the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. One GP showed us how patients were followed up as appropriate if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had many ways of identifying patients who needed support, and it was pro-active in offering additional help. A nurse we spoke with told us there were a number of services available for health promotion and prevention. These included clinics for the management of diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, coronary heart disease (CHD) and cervical screening. The practice had also identified the smoking status of 94.3% of patients over the age of 16 and actively referred these patients to local smoking cessation clinics.

There was a private room away from the reception area known as the health promotion pod. All patients could access this room throughout the course of the day. This room had in excess of 30 information leaflets providing meaningful and relevant information on various conditions, health promotion, support organisations and alternative care providers. This room also contained several pieces of equipment which patients could use to manage and record their height, weight and blood pressure.

There was a range of information available to patients on the practice website including the services available at the practice, health alerts and latest news. The website included links to a range of patient information, including for travel immunisations, NHS health checks and the management of long term conditions.

GPs and nurses sign-posted young patients to local sexual health services for further support and advice. They also provided advice and support for patients wishing to lose weight and often referred patients to local support groups.

The practice's performance for the cervical screening programme was 82.6%, which was slightly above the national average of 81.9%.

The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening, this was reflected in data from Public Health England:

- 65.7% of patients at the practice (aged between 60-69) had been screened for bowel cancer in the last 30 months; this was higher than the CCG average of 62% and higher than the national average which was 58%.
- 81% of female patients at the practice (aged between 50-70) had been screened for breast cancer in the last 36 months; this was higher than the CCG average which was 78% and higher than the national average which was 72%.

Records showed the GPs proactively sought and promoted improvement in immunisation management and this was evident in the immunisation data as the practice was above both local and national averages for influenza and childhood immunisations. Childhood immunisation rates for the vaccinations given in 2014/15 to under two year olds ranged from 90% to 97.6% and five year olds from 92.3% to 98.5%. These were above the CCG and national averages.

Last year's performance for all influenza immunisations was higher than the CCG average and the national average where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 78.4%, and at risk groups 63.9%. These were above CCG and National averages.
- Flu vaccination rates for patients with diabetes (on the register) was 95.1% which was above the National average of 93.5%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the January 2015 national patient survey results (122 respondents), NHS Choices website (16 reviews) and comment cards completed by patients as part of the family and friends test. The evidence from all these sources showed patients were satisfied with how they were treated, and this was with compassion, dignity and respect.

Data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. For example:

- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national averages which were both 95%.
- 92% of patients said the GP gave them enough time compared to the CCG and national average which were both 87%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 completed cards all but two were highly positive about the service experienced. Patients said the practice offered an excellent service and staff were sincere, welcoming and caring. They said staff treated them with respect and were genuinely interested in their wellbeing.

We also spoke with 13 patients on the day of our inspection and the experience of these patients further supported the feedback in the comments cards. This included four members of the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

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

Staff were mindful of the practice's confidentiality policy when discussing patients' confidential information to ensure that it was kept private. Phone calls from patients and other healthcare professionals were taken by administrative staff in a separate area where confidentiality could be maintained.

Patient feedback and a report shared among local GP practices identified patients were concerned about privacy at GP reception desks. The practice had introduced privacy screens for the reception area and a system that encouraged one patient at a time to approach the reception desk. This had helped to reduce the risk of other patients overhearing private conversations.

We observed staff interacting with patients in the reception, waiting rooms and on the telephone. All staff showed genuine empathy and respect for people, both on the phone and face to face.

We saw how a vulnerable patient was appropriately supported by staff to attend their appointment at the practice.

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:

- 89% said the last GP they saw was good at explaining tests and treatments which was higher when comparing to the CCG average of 88% and national average of 86%.
- 90% said the last nurse they saw was good at explaining tests and treatments which was the same as the national average and slightly higher when compared to the CCG average of 89%.
- 89% said the GP was good at involving them in decisions about their care which was higher when compared to the CCG average of 81% and national average of 82%.

Patients we spoke with on the day of our inspection told us 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 92% said the last GP they spoke with was good at treating them with care and concern which was higher when compared to the CCG average of 86% and the national average of 85%.
- 90% said the last nurse they spoke with was good at treating them with care and concern which when compared was similar to both the CCG average of 91% and the national average of 90%

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. These highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen, in the new patient registration pack and patient website also told patients 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.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We saw information leaflets for national and local bereavement support services were available in a dedicated health promotion and patient information room.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to patient's needs and had systems in place to maintain the level of service provided. The practice held information about those who needed extra care and resources such as those who were housebound, patients with dementia and other vulnerable patients. This information was utilised in the care and services being offered to patients with long term needs. For example patients who were housebound were provided with regular contact and given priority when contacting the practice to organise appointments and treatments. We were able to see records of contacts and appointment scheduling for housebound patients which corroborated what we had been told.

The practice was engaged with their Patient Participation Group (PPG) and feedback from patients was obtained proactively. There were regular meetings of the PPG attended by the practice manager and the deputy practice manager. 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) and patient surveys.

The practice worked with the PPG to organise patient education meetings. These were held at the practice and were open to any patient who wished to attend. Recent topics covered included; resuscitation, first aid, heart disease and men's health. We were told these education meetings were very well attended.

Patients aged over the age of 75 years had a named GP who was responsible for their care and support. Home visits and telephone consultations were available for patients who required them, including housebound patients and older patients.

Two GP partners had an enhanced role with the Clinical Commissioning Group (CCG) and engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice.

The practice supported two local care homes for older people. We spoke with representatives from each home who told us the practice staff were very supportive and always responded to their requests to see a patient in a timely and professional way.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointments were available for those with long-term conditions, learning disabilities and those experiencing poor mental health.

Current data on the ethnicity of the local population was not available. However, data from the 2011 census identifies that 89.9% of the local population describe their ethnicity as white British. We were told by the practice that this was reflected on the patient list which was similar to other practices in the locality.

All patient services were located on the ground floor. The practice had clear, obstacle free access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms.

Toilets were available for patients attending the practice, including accessible facilities with baby changing equipment.

The practice demonstrated an awareness and responsiveness to the needs of those whose circumstances made them vulnerable. Facilities for disabled people included an induction hearing loop throughout the practice for patients who used hearing aids, a lower reception desk for people in wheelchairs, braille signs for visually impaired patients and a disabled toilet.

The practice had access to translators via a telephone translation service. Staff told us there was little call for the service as most patients were able to speak English but if required they were confident to use the translation service.

Staff we spoke with said they had completed equality and diversity training. Staff confirmed that equality and diversity was discussed at staff meetings.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us there was an open policy for treating everyone as equals and there were no restrictions in registering. Although there were no patients with "no fixed abode" staff told us homeless travellers would be registered and seen without any discrimination.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The practice was open from 08:00 to 18:30 Monday to Friday. There was also morning (07:30-08:00) and evening (18:30-19:00) phone consultation service for patients. The practice opened on alternate Saturdays and provided pre-bookable appointments between 08:30-11:30.

The practice was looking at how they could improve the appointment experience and access to meet the demand for appointments at known busy times. In March 2015, the practice used patient feedback, consulted with all practice staff, involved the PPG and implemented key changes to the appointment system.

Appointment information was available to patients in the practice through a new appointment leaflet, via a large TV screen in the reception area and on the practice website. Information on the practice website also included how to arrange urgent appointments, home visits, routine appointments and how to cancel appointments.

The practice relocated to a purpose built building in 2003 on the edge of Newbury. The new location of the practice is not served by a local bus service. Following relocation a dedicated practice bus was available to patients who required access to the practice. This service ran three mornings a week and collects patients directly from their home address and returns the patient back following their appointment. Several patients we spoke with on the day of inspection used this service and described the practice bus service as an excellent and efficient service.

Longer appointments was also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one. The named GP also made same day home visits for patients who needed urgent attention.

We saw data from GP National Patient Survey and in house patient surveys had been reviewed as patients responded negatively to questions about access to appointments. For example:

- 84% of respondents said the last appointment they got was convenient. This was below the CCG average 91% and below the national average 92%.
- 58% of respondents found it easy to get through to the practice by phone. This was significantly lower than CCG average 79% and national average 74%.
- 60% described their experience of making an appointment as good; which was significantly lower than CCG average 78% and the national average 74%.

This was not reflected in comments from patients we spoke with and comments left on CQC comment cards. Patients we spoke with on the day were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

We observed and spoke with patients in the waiting area of the practice. The majority of patients we spoke with were complementary about the service they received. However one patient we spoke with had been waiting for almost an hour for their appointment. They had not been advised by staff that the GP was running late until approaching the receptionist to ask about the delay themselves.

Reception staff told us some appointments were pre-bookable and some had been allocated for booking on the same day and for patients to book online. We observed there were appointments available on the day of the inspection and the following day.

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 information was available to help patients understand the complaints system in the practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

complaints leaflet, which was available within the reception area. Information about how to and who to complain to was displayed on TV screens in the reception area. Information about how to and who to complain to was detailed in full on the practice 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 10 complaints received in the last 12 months and found these were dealt with in a timely way in line with the complaints policy and there were no themes emerging.

The practice reviewed complaints annually to detect themes or trends. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, in one case where a complaint had been raised with the practice due to a repeat prescription request being denied. The practice was able to provide evidence of the complaint which highlighted how it was managed and refresher training on patient prescriptions.

We also looked at eight compliments received in the last three months and found these had been shared with all staff and were discussed in meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

There was a clear vision and strategy for the delivery of high quality, safe and effective care and treatment. We spoke with nine members of staff who all showed their commitment to the values of the practice. The Statement of Purpose of the practice set out its commitment to providing the best care and treatment to patients:

The vision and statement of purpose evolved from a practice away day which all staff attended. All staff and GPs were involved in the development of this statement.

The practices statement of purpose included their six main aims and objectives how the practice would achieve their aims. The statement of purpose and a summary of these were also displayed on the practice website.

Our discussions with staff and patients indicated the vision and values were embedded within the culture of the practice. Staff told us the practice was patient focused and they told us the staff group were well supported.

The majority of the staff had worked at the practice for many years and told us it was a good place to work.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and support the safe running of the practice. These were available to staff via the IT system and physical copies were stored in a readily available folder. We looked at six of these policies and procedures, all policies had been reviewed annually, version controlled and were up to date.

The practice manager and deputy practice manager were responsible for human resource policies and procedures. We reviewed a number of policies such as the induction programme, disciplinary procedures and grievance process which were in place to support staff. We saw the staff handbook that was available to all staff, which included sections on equality, whistleblowing and harassment at work. Staff we spoke with knew where to find these policies and staff handbook if required.

The governance arrangements in place were designed to support the practice as it grew, in the number of services it provided as well as the number of patients it served.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took time to listen to all members of staff. Staff told us there was an open and relaxed atmosphere in the practice and there were opportunities for staff to meet for discussion or to seek support and advice from colleagues. Staff said they felt respected, valued and supported, particularly by the partners and management in the practice.

The recently recruited receptionist at the practice spoke of the quality of leadership and support received. Arrangements were made to provide access to a mentor and a comprehensive induction was offered when starting work at the practice.

There was a clear leadership structure with named members of staff in lead roles. All staff were clear on their responsibilities and clear lines of accountability were in place. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding.

Following a practice away day, all staff had been involved in creating and embedding Falkland Surgery aspirations into everyday life at the practice. An example of a practice aspiration was to value and recognise contributions from the team.

We spoke with nine 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.

All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We were told team meetings were held regularly, at least monthly and clinical meetings were held every week. We saw minutes and attendance lists for staff meetings, we found performance; quality and risks were discussed at the meetings.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

We found the practice to be very involved with their patients, the Patient Participation Group (PPG) and other stakeholders. We spoke with four members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

There was evidence of regular meetings and PPG members' involvement in undertaking practice supported initiatives. For example the practice and PPG members had arranged an open evening facilitated by the practice with clinical overview by a lead GP with the focus on a healthy prostate. Other open evening events taken place included resuscitation and First Aid.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice. In March 2015, the practice surveyed patients and following feedback reconfigured the appointment system in line with patient views.

The PPG had regular fundraising events with a view of purchasing equipment for the practice. We saw evidence of the PPG had purchased various pieces of equipment. For example, a digital camera which had helped to record the treatment of leg ulcers and a cautery tool used in minor surgery.

The practice was engaged with Newbury and District Clinical Commissioning Group (CCG), the local GP network and peers. We found the practice open to sharing and learning and engaged openly in multi-disciplinary team meetings. The relationship between the PPG and the practice was strong with regular meetings that were attended by practice GPs and practice management.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five files and saw that regular appraisals took place which included personal development plans. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of children and vulnerable adults.

Staff told us that the practice was very supportive of training. One member of staff told us about a recent leg ulcer refresher training session that they had attended and showed detailed plans of a cardiovascular disease study training day which they will be attending in July 2015.

The practice was a GP training practice and at the time of the inspection had an Army GP working who was gaining experience to enter General Practice. A further trainee GP was due to join the practice in July 2015.

We saw a number of innovative schemes had been implemented or were in the process of development within the practice in order to improve the care for their patients.

The practice was involved in research development to help support best clinical practice. For example, the practice led a pioneering scheme to identify patients who were identified as high risk and had a likelihood of developing diabetes within the next 20 to 30 years. A practice GP designed and implemented the project and diabetes tool to improve detection of diabetes among 100,000 patients in the local Clinical Commissioning Group for which they won an award.

At risk patients with a high body mass index were identified and encouraged to join a weight-loss programme to help improve their outcome.

The practice had also been involved in a project identifying latent Chronic Obstructive Pulmonary Disease (COPD) called "Missing Millions". Awareness events were held to identify the patients who have COPD without knowing it, and then provide the help and support they need. The practice achieved 100% QOF points for care and treatment of COPD. Overall the practice achieved 99.5% QOF points out a possible 100%, which was above the National and local average.

The practice had completed reviews of significant events and other incidents and shared learning with staff via meetings to ensure the practice improved outcomes for patients. For example, following an incident which involved a recognised medication complication, the practice had reviewed and updated the system for requesting referrals.