Langley Health Centre

Quality Report

Common Road
Langley
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Langley Health Centre, Common Road, Langley, Slough, Berkshire, SL3 8LE on the 12 May 2015. This was the first inspection under the new CQC comprehensive inspection approach and was undertaken to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The practice demonstrated a commitment to continuous improvement through learning and responding to patient feedback and we have rated the practice overall as outstanding. The ratings underpinning this are provision of outstanding effective services and outstanding for being well led. The practice is rated as good for the delivery of safe, responsive and caring services.

The provider has a second practice located in Colnbrook. We did not inspect this service because it is registered separately with the CQC.

Our key findings were as follows:

- The practice had robust systems in place to safeguard patients from potential abuse. Staff were appropriately trained in safeguarding and one GP was the safeguarding lead for the CCG. Learning from safeguarding board meetings and child protection reviews was disseminated widely within the practice.
- Systems to safely manage medicines and reduce the risk of cross infection were operated.
- A range of appointments were available including clinics on both Saturday and Sunday each week. However, some patients were not aware of the availability of these appointments.
- The practice was committed to learning from complaints and other recorded incidents. Complaints were dealt with in a comprehensive manner and learning from them was shared with the practice team.
- Learning from incidents was shared with both staff and other practices in the area. The practice took an active role in the local health community and constantly strove to expand and improve the services it offered.
- The practice was aware of, and actively sought, patient feedback. There was evidence that the practice took

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action to address patient feedback. A new telephone system had been installed in 2014 to assist in answering calls more rapidly and online booking of appointments was in place.

- Patients we spoke with and CQC comment cards completed reported that staff were kind and caring and that reception staff were polite and professional. The practice had invested in customer care training for reception staff.
- The practice had a clear vision which placed learning, quality and safety as top priorities. The plan was monitored and shared with staff and the patient participation group. High standards were promoted and owned by the practice team.
- Completion of two cycle audits that identified actions to improve patient care and outcomes and evidence that improvements were achieved. For example, prescribing of a combination of two medicines which had the potential to interact was audited twice and the number of patients taking both medicines had reduced by 46%.

We saw several areas of outstanding practice including:

- The practice was open seven days a week providing access to appointments on both Saturday and Sunday. The weekend clinics were shared with another local practice.
- The practice had a clear vision, a strong learning culture and was committed to continued quality improvement. Quality improvement was supported by taking a community wide approach to health in bringing learning back to the practice from and sharing information with the CCG. The practice risk register was supported by use of a risk stratification tool.
- An open approach to seeking patient feedback and acting upon it. Open evenings held in conjunction with the Patient Participation Group enabled patients to bring any issues to the attention of the GPs and management.
- The practice had an open culture in sharing learning. This included liaisons with neighbouring practices to share information about significant events and rare presentations of clinical conditions.
- When complaints were received relating to quality of consultations experienced GPs coached other members of the team in good consultation techniques and there had been no further complaints since the coaching session.

There is an area where the provider should make improvement and this is:

- Improve the promotion of the availability of extended hours surgeries to ensure all patients are aware of these.

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 placed the safety of care and treatment at the core of their activities. Provision of safe care was included in the practice core values and mission statement. 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 including sharing with other local practices in the clinical commissioning group. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed by the use of risk management tools. There were enough staff to keep patients safe.

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. Clinical audit to review performance and improve outcomes for patients was embedded within the practice culture and we saw 13 audits had been undertaken in 2015. The practice was active in meeting local targets for improving quality.

Are services caring?

Good 

The practice is rated as good for providing caring services. Data showed that where patients had given mixed feedback about their care in the past the practice had addressed the concerns. Recent surveys showed patient feedback was improving and was comparable to other practices in the area. Patients said they were treated with compassion, dignity and respect. 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?

Good 

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had worked with a neighbouring practice to secure funding to provide evening and

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weekend appointments and offered patients a variety of ways to book and access these. Patients said they found it easy to obtain urgent appointments and that access to book appointments was improving. However, some patients we spoke with were unclear about the booking process to obtain weekend appointments. 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 but some complaints were not responded to in a timely manner.

Are services well-led?

Outstanding 

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality, learning and safety as its top priorities. The vision had been produced with stakeholders and was regularly reviewed and discussed with staff. 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. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using various methods including open evenings and it had a very active patient participation group (PPG).

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 patients. The practice is rated outstanding for the delivery of effective services and for being well led and this applies to all population groups. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients and we noted the practice had the highest number of patients aged over 65 in the area. The practice offered proactive, personalised care to meet the needs of the older patients 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 patients, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of patients with long-term conditions. The practice is rated outstanding for the delivery of effective services and for being well led and this applies to all population groups. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Data showed that the practice was performing at a higher than average level for the care of patients in this group. For example 100% of the targets for caring for patients with diabetes were met in 2014/15. 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. Patients received a phone call from the practice the evening before their health check appointment to remind them of the importance of the review. 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.

Families, children and young people

Outstanding

The practice is rated as outstanding for the care of families, children and young people. The practice is rated outstanding for the delivery of effective services and for being well led and this applies to all population groups. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. The practice combined mother and baby health checks with first immunisations and this

assisted in maintaining high immunisation rates. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Health visitors gave us examples of the prompt support they received from GPs when they had concerns about children's health and wellbeing. The lead GP for child safeguarding regularly attended the local safeguarding board and was the CCG lead for safeguarding.

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 practice is rated outstanding for the delivery of effective services and for being well led and this applies to all population groups. 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 and flexible. Telephone appointments were available and the practice offered appointments during the evening and at the weekend. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice is rated outstanding for the delivery of effective services and for being well led and this applies to all population groups. It is also rated as outstanding for being responsive to the needs of this patient group. The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability. It had carried out annual health checks for 96% of patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. 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 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)

Outstanding ☆

The practice is outstanding for the care of patients experiencing poor mental health (including people with dementia). The practice is rated outstanding for the delivery effective services and for being

Summary of findings

well led and this applies to all population groups. Data showed the practice achieved 100% of the national targets for caring for patients with severe mental health problems including undertaking physical health checks. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Talking therapies were available on site. The practice carried out care planning for patients with dementia. There was evidence of close liaison with community mental health teams and with local consultants. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The results from the national patient survey undertaken in 2014 and completed by 116 patients showed a varying level of satisfaction with the services provided by both GPs and nurses at the practice. The confidence and trust ratings in both GPs and nurses were high with 94% stating they had confidence in the GPs and 96% in the nurses. Patient satisfaction with the overall service was increasing. A survey of 100 patients conducted in February 2015 and the friends and family test results for three months showed that the number of patients who would recommend the practice had doubled since the last national survey with over 86% saying they would recommend the practice to others. Survey data also showed that patients felt they had sufficient time to discuss their concerns and that GPs and nurses listened to concerns. However, the national survey identified that patients found difficulty in accessing the service and we saw that the practice had taken action to address this.

We received 78 completed CQC comment cards. These had been filled out by patients who attended the practice in the two weeks prior to our inspection. Seventy four of the comments were positive about the care patients received. We found eight patients were less positive about access to telephone booking of appointments and the practice had recognised the challenge of improving booking facilities. Patients also commented on the improvement in service from reception staff in the last year.

We spoke with 12 patients on the day of the inspection. Again we received positive feedback from all the patients we spoke with.

Areas for improvement

Action the service SHOULD take to improve

- Improve the promotion of the availability of extended hours surgeries to ensure all patients are aware of these.

Outstanding practice

- The practice was open seven days a week providing access to appointments on both Saturday and Sunday. The weekend clinics were shared with another local practice.
- The practice had a clear vision, a strong learning culture and was committed to continued quality improvement. Quality improvement was supported by taking a community wide approach to health in bringing learning back to the practice from and sharing information with the CCG. The practice risk register was supported by use of a risk stratification tool.
- An open approach to seeking patient feedback and acting upon it. Open evenings held in conjunction with the Patient Participation Group enabled patients to bring any issues to the attention of the GPs and management.
- The practice had an open culture in sharing learning. This included liaisons with neighbouring practices to share information about significant events and rare presentations of clinical conditions.
- When complaints were received relating to quality of consultations experienced GPs coached other members of the team in good consultation techniques and there had been no further complaints since the coaching session.

Langley Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, two CQC inspectors 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. The team was accompanied by a CQC Inspection Manager in an observer role.

Background to Langley Health Centre

Langley Health Centre provides general medical services to a population of 17,200 patients who live in Langley and Colnbrook. A large proportion of the patients live within the Foxborough ward of Slough unitary authority. Foxborough ward is identified as having a deprivation rating of five in a rating scale of ten. There are 12 GPs working at the practice. There are four GP partners, six salaried GPs and two long term locum GPs. In addition two GPs were providing maternity leave cover. There is an equal split of six male and six female GPs. The practice employs four practice nurses and one health care assistant. There is a trainee practice nurse working at the practice. In addition there is an interim practice manager supported by a team of administration and reception staff. The practice is a training practice and is accredited to support up to four GPs in training at any one time.

The practice delivers services via a General Medical Services (GMS) contract (GMS contracts are negotiated nationally between GP representatives and the NHS). The patient population at the practice is growing with over 850 new patients registered within the last year. Within the registered patient group there is a higher than average number of patients under the age of 18 compared to other practices in the area. The practice had not been inspected before.

The practice is open between 8am and 8pm Monday to Friday and between 9am and 5pm on Saturday and Sunday. Appointments are from 8am every morning and to 6.20pm daily. Extended hours surgeries are offered at the following times every weekday, 6.30pm to 7.30pm and every Saturday and Sunday between 9am and 4.45pm.

Services are provided from:

Langley Health Centre, Common Road, Langley, Slough, Berkshire, SL3 8LE and Dr N Adam and partners, 12 Wheelwrights, Place, Colnbrook, Slough, Berkshire, SL3 0JX.

We did not inspect 12 Wheelwrights Place as this location is registered separately with the CQC.

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided by East Berkshire Primary Care Out of Hours. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice, in the practice information leaflet and on the patient website.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before. 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.

How we carried out this inspection

Prior to the inspection we contacted the Slough Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Langley Health Centre. We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

The inspection team carried out an announced visit on 12 May 2015. We spoke with 12 patients, five GPs, a GP in training and eight staff. We reviewed 78 CQC comment cards that had been completed in the two weeks prior to our inspection. As part of the inspection we met with the interim practice manager and looked at the management records, policies and procedures.

Staff from the local NHS Trust also have offices within the Health Centre and we took the opportunity to meet with the Health Visitors whilst carrying out the inspection. They told us they had an excellent relationship with the GPs at the practice and were able to share concerns promptly. Langley Health Centre does not provide services to local care homes or schools.

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 saw that an incident reported relating to entering a wrong date of birth when accessing patient notes. The GP concerned reported the incident and the patient received an apology. GPs and nurses were reminded to ensure accuracy when accessing notes.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. We saw that the lead GP either initiated an audit or a records check when alerts were received relating to medicines or equipment. The results were tracked and action taken and this was confirmed by the notes we reviewed of the practice clinical governance meetings. The practice had managed safety consistently and 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 year and we were able to review all 25 of 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 significant events and that the findings were shared with relevant staff and also with the CCG. For example, when a problem arose with a piece of equipment commonly used for a diagnostic test the practice shared their concerns and their learning with the CCG. GPs and management kept staff informed of the learning from significant events by displaying information on screens in staff areas which were not accessed by patients. 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 reported incidents to their line manager, senior GPs or the practice manager. Incident forms were then completed and placed on the agenda for the next practice meeting.

We reviewed the incident log and the minutes of meetings where significant events had been discussed. These showed us that all incidents were recorded, discussed and completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example when a problem arose with the registration of a new patient the registration system had been reviewed and updated to prevent a similar occurrence happening in the future. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

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. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns. They knew where to find the details of the local safeguarding authority and other relevant agencies in working hours and out of normal hours. We saw contact details were displayed in staff areas.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. For example, all GPs had been trained to level three in child safeguarding and nurses to level two. The lead GP for child safeguarding was also a lead for the CCG and attended the local safeguarding board meetings whenever they were able. There was evidence that learning from attendance at safeguarding board and case reviews were shared with other members of the team. For example, new protocols were disseminated and GPs were made aware of the need to follow up children who attended the practice regularly. These children were allocated a named GP.

All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern. We also spoke with the health visitors who worked with the practice. They told us they had open channels of communication with the GPs that were both informal and

formal. Health visitors met with the lead GP for child safeguarding every month and had access to the practice patient records to update information on children at risk or who gave rise to concern.

There was a system to highlight vulnerable patients on the practice's electronic records and we checked records that showed us this system was actively used. For example, children subject to a child protection plan were identified as were children who attended A&E frequently. Staff who booked appointments told us how they checked the alerts to see if young patient's needed to be seen urgently when they called for an appointment.

There was a chaperone policy, which was displayed on the patient information screen in the waiting room and in 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). All nursing staff had been trained to be a chaperone. Some reception and administration staff had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. These staff had completed criminal records checks and we noted that staff that were trained but had not yet completed their criminal records (DBS) checks were not permitted to carry out chaperone duties.

Medicines management

We checked medicines kept in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Practice staff were aware of the action to take if the fridge temperature was not maintained and we saw that the procedure had been followed when a medicine fridge had been inadvertently turned off.

We saw the cold chain policy which the practice staff followed included the safe disposal of expired medicines, in line with waste regulations, Health Protection Agency guidance and Vaccination Immunisation direction from Public Health England. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

The practice had a policy and procedure for dealing with dangerous medicines. We saw that there was a robust system in place to ensure patients on these medicines received appropriate tests before their prescriptions were dispensed. For example, the practice had initiated a clinic to review patients taking blood thinning medicines and patients were required to attend for their tests and results before their medicines were prescribed. There was also a system for reviewing patients with rheumatoid arthritis which ensured appropriate tests were undertaken and the results reviewed before medicines were prescribed and dispensed.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. They also attended update training in the specific clinical areas of expertise for which they lead. For example initiating and adjusting doses of insulin for patients with type two diabetes.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. 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 a lead for infection control supported by two deputies. This team met regularly to review, discuss and action any infection prevention control concerns affecting the practice. All members of the practice infection prevention control team demonstrated an excellent understanding of their role and were sufficiently well trained to advise others on infection control matters.

The practice was cleaned twice daily; cleaning schedules (daily, weekly and monthly) were followed, monitored and audited. We saw evidence that when issues were identified they were raised with the cleaners directly. We saw that

cleaning material and products were stored safely and securely and that safety data sheets were held for the cleaning products in use. This meant that the products were used safely and cleaners had information on how to use the products safely and what to do if the products were spilt. The required Control of Substances Hazardous to Health (COSHH) regulations were therefore being followed.

Staff received induction training about infection control specific to their role and received annual updates. There was also evidence of staff completing online refresher training on infection control and staff we spoke with were able to tell us about their roles in reducing the risks of cross infection. For example, reception staff demonstrated a safe process for receipt of specimens. We saw evidence that the Infection Control team, led by the Infection Control Lead had carried out an infection control audit in April 2015, the improvements identified were shared with the practice team and action plans were created to implement the changes. The practice had a plan to re-audit in 6 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, hand washing guidance and subsequent hand washing audits for all practice staff. These ensured all staff complied with the practice's infection control policy.

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 in order to comply with the practices infection control policy. Observations were made of the team correctly using and disposing of their personal protective equipment throughout the course of the day

The practice had taken responsible steps to protect staff and patients from the risks of health care associated infections. We saw that staff had received the relevant immunisations and support to manage the risks of health care associated infections.

There was a policy for needle stick injury and staff knew the correct procedure to follow in the event of an injury. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company at timely intervals to prevent a potential build-up of clinical waste.

The practice had a policy for 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 2014 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 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 that the next test was not due until March 2016. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the fridge thermometers. Records we reviewed showed us that non-medical equipment and the building were maintained. For example there were records of the boilers being serviced, the electrical supply in the practice had been checked and passed safe and the automated entrance doors were serviced in accordance with manufacturers' instructions.

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.

The GPs and interim practice manager 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. For example, the part time medical secretary increased their hours when the full time

medical secretary was on holiday. 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.

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. The health and safety policy was supported by a range of relevant risk assessments including Manual Handling and access and egress to the practice.

There was a practice risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed by GPs at team meetings and the practice governance meetings. The identification of risks was used to trigger audits. For example, when a vaccine fridge had been turned off accidentally the practice audited their vaccine fridge safety processes.

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. 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 a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training, and that they practised fire drills. Records also confirmed that the fire alarm system and fire fighting equipment were maintained.

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. These were easily accessed from a shared drive on the practice computer system. 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.

We saw that GPs took a lead in specialist clinical areas such as diabetes, heart disease and asthma. There was evidence that the lead GPs in each area had received appropriate additional training to carry out their roles. The lead responsibilities were displayed on organisational lists throughout the practice and staff were able to access these easily. Staff therefore, knew which GP to approach if they had questions relating to specific conditions and diseases. Practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We reviewed data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be contacted within three days of receipt of their discharge letter.

The national data available to the CQC had shown the practice as high referrers to hospital and other community care services for a number of conditions. The GPs were aware of this historical data and had introduced systems to ensure all referrals were made appropriately. A system of referral reviews had been introduced and proposed referrals by newly qualified and salaried GPs were reviewed by the senior GPs. We saw that this had resulted in the practice achieving and surpassing the local CCG referral targets. Consequently referrals in 2014 and 2015 were in line with, or better than, national referral rates. All GPs we spoke with used national standards for the referral of patients with suspected cancer and we saw that there was a tracking system in place to ensure these patients were seen within the target of two weeks.

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 managing child protection alerts and medicines management. The information staff collected was used by the GPs to support the practice to carry out clinical audits.

There was an audit plan which demonstrated how the practice was committed to continually improving the outcomes of their patients. The practice showed us 13 clinical audits that had been undertaken in 2015 and we saw that the practice was active in carrying out similar numbers of audits in previous years. Over 70% of audits we saw were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the practice undertook an audit to check that the prescribing of specific types of blood pressure lowering medicines combined with cholesterol lowering medicine met the national prescribing guidance. The first audit demonstrated that 50 patients were receiving repeat prescriptions for these medicines following their medicine reviews. The information was shared with GPs and the prescribing guidelines were reiterated. The second cycle of the audit, six months after the first, showed a reduction to 27 patients who were still receiving both the medicines. The practice was taking further action to reduce the number and the audit was to be repeated in six months' time.

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). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit of

the joint injections undertaken at the practice. This identified two patients who had not signed written consent for their injection. The system was made more rigorous to ensure all patients gave written consent and the audit was set to be repeated in one year. GPs maintained records showing how they had evaluated the service and documented the success of any changes. The audit records and minutes of meetings showed us that all GPs were active in audit including the salaried GPs and the GPs in training. We also noted that practice nurses attended meetings where audit results and learning were discussed. Practice nurses had completed audits on hand washing techniques, the vaccine cold chain and infection control. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all GPs staff should undertake at least one audit a year.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of the national targets for patients with diabetes had been achieved in the year 2014/15. This performance was better than most practices in the CCG. The practice met all the minimum standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease). Historical data showed that the practice had excluded a slightly higher number of patients with Mental Health problems from QOF monitoring in the year 2013/14. We reviewed some of the exceptions and found they met the exception criteria. The practice was not an outlier for any QOF (or other national) clinical targets.

The practice had achieved the national targets for care of patients experiencing poor mental health. This included completion of annual physical health checks. We saw that patients with dementia had care plans in place which were regularly reviewed and that the diagnosis rate of dementia was increasing.

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. The practice had a system of telephoning patients booked for review of their long term condition on the evening before their appointment. This reminded patients of the importance of their review and reduced the number that missed their appointment. The practice computer system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We noted that the needs of patients who had a new diagnosis of cancer were also discussed by the team at this forum. The practice also held a register of patients who had passed away and the circumstances of their death were discussed to determine learning from the care and treatment the patient received from the practice prior to their death.

The practice also participated in the local CCG quality innovation, productivity and prevention (QIPP) programme. This is a process of setting local quality targets and comparing practice achievements. The local data showed the practice to be among the best performers in referral rates medicines management.

Doctors at the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and keep up to date. They also regularly carried out clinical audits on their results and used that in their learning.

Effective staffing

Practice staffing included GPs, practice nurses and managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with six having additional diplomas in obstetrics and gynaecology and one holding a qualification in occupational medicine. 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 one member of staff had undertaken training in team building and motivation. 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 trainee we spoke with and saw that the practice had received positive review from previous trainee GPs in the General Medical Council trainee survey in 2014.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, in administration of vaccines and cervical cytology. Those with extended roles for example, seeing patients with long-term conditions such as asthma, COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

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 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice followed up patients discharged from hospital. We saw that the policy for taking action on hospital communications was working well in this respect.

The practice worked closely with the local community mental health team and accessed advice from consultants in psychiatry when appropriate. There was a visiting talking therapies service to which patients who would benefit from this particular intervention were referred.

The practice held multidisciplinary team meetings once a month 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, palliative care nurses and health visitors and decisions about care planning were documented in the meeting minutes. Both the health visitors and district nurses had offices at the practice and access to the practice patient records. The health visitors we spoke with told us they were able to update patient records with new information directly. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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, and the practice made 85% of referrals last year through the local referral management centre which then operated the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that the referral system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and this was in operation at the time of our visit. (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 to coordinate, document and manage patients' care. All staff were fully trained on the system and we saw records of their training. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that staff 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. We saw that when a do not attempt to resuscitate order had not been completed correctly the practice took immediate action to correct it and logged the incident as a significant event. There was evidence that the correct procedure had been reiterated to avoid similar occurrences in the future.

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 completing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). 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. Both GPs and nurses demonstrated a clear understanding of Gillick competencies. (These are 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 documenting consent for specific interventions. For example, for all minor surgical procedures required written consent from the patient. We noted that when an audit revealed two patients had not consented to their joint injections the practice took action to ensure written consent was obtained for all procedures.

Health promotion and prevention

The practice engaged with the CCG to discuss the implications and share information about the needs of the practice population. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the practice nurses for patients aged between 40 and 75. The practice had identified that they could improve the uptake of this important preventative check. In the last two months 3000 text messages had been sent to eligible patients and over 300 additional health checks had been completed. 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 to 25 years and offering smoking cessation advice to smokers.

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 39 out of 41 of these patients received their health check in the last year. The practice had also identified the smoking status of 86% of patients over the age of 16 and actively offered smoking cessation support from a dedicated on site team to these patients. We were shown an award the practice received in 2014 for achieving the highest referral and quitter rate for the stop smoking initiative in the area. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. The practice met the 100% QOF target for identifying patients who were clinically obese. These groups were offered further support in line with their needs. The practice worked with the patient participation group (PPG) on initiatives to improve healthy lifestyles. For example the PPG had established a programme of health walks designed to encourage patients to increase their physical activity.

The practice's performance for cervical smear uptake was 80%. This met the national 80% target and was similar to other practices in the CCG area. A named nurse had been designated to telephone patients and remind them of the importance of this test and the practice audited patients who do not attend. Data showed us the practice was in the top two in the CCG for take up of breast screening with just over 73% of those eligible attending for this test. Performance for national bowel screening showed the practice in the top six in the CCG with 45% of patients attending for screening.

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 all childhood immunisations exceeded the national 90% target and again there was a clear policy for following up non-attenders by the named practice nurse. The practice maintained high immunisation uptake by combining

Outstanding ☆

Are services effective?

(for example, treatment is effective)

mother and baby health checks with the administration of first immunisations. We noted that the practice achieved 65% flu vaccination rate for patients aged over 65 and this was slightly below other practices in the CCG.

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 national patient survey, of 116 respondents, from 2014, a survey of 100 patients undertaken by the practice's patient participation group (PPG) in February 2015 and the friends and family satisfaction data up to March 2015. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice achieving similar ratings to other practices in the CCG and in some areas performing better than others. The satisfaction scores on consultations with doctors and nurses were positive, with 88% of practice respondents saying the practice nurses were good at listening to them compared to a local average of 85%. The GPs also scored highly on this question with 84% of patients rating this good or very good. We reviewed the results of the PPG survey from February 2015. This showed an improving satisfaction rating with 88% of patients stating they were satisfied with the care they received. Data from the friends and family test showed 84% of patients who responded would be likely or very likely to recommend the practice to other. This showed a significant increase from the 43% who responded to this question in the national survey.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 78 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Eight comments were less positive but these focussed on telephone access to appointments. The practice were aware of the patient perception of this aspect of their service. We also spoke with 12 patients on the day of our inspection. All told us they were generally satisfied with the care provided by the practice and said their dignity and privacy was respected.

We observed that all consultations and treatments were carried out in the privacy of a consulting or treatment 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 and 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. Calls from patients were received in an office away from reception which helped keep patient information private. There was a system to encourage only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. We also observed reception staff greeting patients in a professionally polite and friendly manner. A number of the patients we spoke with and the comment cards we received were positive in regard to the caring nature of reception staff and they noted an improvement in the customer care given by this group of staff in recent months.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients were not as positive about their involvement in care planning decisions compared to other local practices. Only 69%, who answered this question, felt GPs were good or very good and 77% gave a good or very good rating for the practice nurses. Minutes of a clinical governance meeting from late 2014 showed that the experienced GPs had undertaken coaching of the less experienced GPs in improving consultation techniques. The practice held a number of disease and specific medical condition related patient registers. These detailed that patients had care plans in place. We noted that the practice had exceeded the target for preparing care plans for 2% of the patients most at risk of hospital admission.

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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language and the GPs and nursing staff spoke a range of languages.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with and comment cards we received were positive about the emotional support GPs and nurses gave them in time of need and in coming to terms with diagnoses of long term medical conditions. We were given examples by patients with long term conditions of the time GPs and nurses took to explain the consequences of the condition and the care and treatment plans to be followed. We were also given examples of GPs taking time to advise patients on the next steps to take if the original treatment plan was not effective.

Staff who processed referrals gave us examples of helping patients to book their hospital appointments and when patients said they were unable to use the booking system these staff made the hospital appointments for them.

Notices and leaflets in the patient waiting room, on the TV screen 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 saw a range of written information available for carers to ensure they understood the various avenues of support available to them.

The practice sent a personalised handmade condolence card to all patients who had suffered a bereavement of their next of kin. The patient was offered the opportunity to make an appointment to see their usual GP. We were given examples of patients being referred to support groups following a bereavement and of patients whose first language was not English being supported through a bereavement by one of the GPs who spoke the patients native language.

Good

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 patient's 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.

One of the GPs was active on the board of the Slough Clinical Commissioning Group (CCG) and we saw that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. For example, the practice was active in achieving the local quality and innovation scheme. The GP who attended the CCG board fed back local priorities to their colleagues and minutes of the practice meetings showed us that this took place. There was evidence that the practice took action on local priorities because the practice was meeting both local prescribing and referral management targets.

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). This included introducing on line booking of appointments before they were required to do so and setting up customer service training for reception staff.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the homeless, patients with a learning disability and carers. The practice held registers of patients with a learning disability and carers and we saw that information for carers was available. Patients who were homeless were able to register with the practice and there was evidence that when they did so the practice address was used. This enabled homeless patients to receive appropriate care and treatment.

The practice had access to online and telephone translation services and the GPs spoke a variety of languages.

The practice provided equality and diversity training through e-learning. Training records we reviewed showed that most staff had completed training and there was an expectation that all staff would complete the training once every three years.

All services to patients were located on the ground floor of the practice. The corridors to consulting and treatment rooms were sufficiently wide to accommodate patients in wheelchairs and those with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

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 8am to 8pm on weekdays and from 9am to 5pm at weekends. The practice did not close during the lunch period. The last booked appointment on weekdays was 7:30pm with provision for emergency walk in patients until 8pm. The last booked appointment during weekends was 4:30pm with provision for emergency walk in patients up to 5pm.

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 most 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 patients who needed them and those with long-term conditions. Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said 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 on the same day of contacting the practice. For example, some of the patients we spoke with

Good

Are services responsive to people's needs?

(for example, to feedback?)

told us they had called earlier on the day of our visit and were seen by a GP later that morning. Another patient gave us an example of being seen within 45 minutes of making a call for urgent assistance with their medical condition.

The practice had the highest number of patients aged over 65 in the area. Services which were frequently accessed by this group of patients including audiology and podiatry were provided on site to reduce the need for patients to travel to hospital or other clinics to access their care.

The practice's extended opening hours held every weekday evening from 6.30pm to 8pm and at weekends between 9am and 5pm were particularly useful to patients with work commitments. This was confirmed by some of the patients we spoke with and by comments we received on CQC comment cards. However, there were also some patients we spoke with who were unclear on how to access the weekend appointments. The practice should review how they promote these extended hours and educate patients in how to access these appointments. We noted that the weekend clinics were shared with another local practice and this showed a commitment to the wider population of the area.

The 78 comment cards we received and the patients we spoke with reflected general satisfaction with the availability of appointments but there remained some concerns at the ability to get through by telephone to book an appointment. We saw some patients queuing when we arrived at the practice and some of these patients commented that it was easier to book in person than to get through by telephone. It was evident that the practice took action in response to these concerns. An upgraded telephone system had been installed in 2014 which had increased the number of phone lines available. An additional member of staff was designated to cover the morning peak periods of phone calls. The practice was promoting the revised arrangements through PPG newsletters.

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 the contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. One of the senior GPs had taken responsibility for dealing with complaints in the absence of a permanent practice manager.

We saw that information was available to help patients understand the complaints system. Details were available at reception, in the patient leaflet and on the practice website. Some 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 saw that 24 complaints had been received in the last 12 months and we looked at a sample of five of these in detail. We found the practice had not met their target to complete an investigation and respond within a month on two occasions during the handover between the outgoing practice manager and the lead GP taking responsibility for complaints. When this occurred the patient had been given a full and detailed response and the GP had apologised for the delay. We noted that the investigation process the practice employed when dealing with a complaint was thorough and well documented. When a complaint related to a specific member of staff the investigating GP met with the member of staff concerned and took a statement from them. Records showed us that all complainants had received a written response to their concerns even if they had held a meeting with the investigating GP or the previous practice manager.

The practice reviewed complaints annually to detect themes or trends. We looked at the report of the last review. The GPs identified that there had been an increase in the number of complaints relating to the quality of consultations and also that there were concerns relating to access to appointments.

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 practice had a clear vision to be the local GP training practice of choice and to deliver high quality and safe care to their patients within an environment of continuous improvement. We found the vision and practice values were part of the practice's strategy. The practice strategy and vision had been shared with the Patient Participation Group. The practice operated with a set of values that had been had been shared with staff and staff were encouraged to comment upon them. The values included; openness and respect, professionalism and team work, listen and learn, participation and involvement and to be local and accessible. We found staff demonstrated the values of the practice.

The management team understood the challenges the practice faced in delivering services in an area of higher than average income deprivation, the largest registered population aged over 65 in the area, increasing numbers of registered patients and higher prevalence of long term medical conditions. There was recognition of the need to provide services as close to the patient as possible and practical, This was evidenced by the provision of a range of services including talking therapies, podiatry, audiology and community dentistry on site.

We spoke with eight members of staff, salaried GPs and a trainee GP. They all knew and understood the values and knew what their responsibilities were in relation to these. For example we found salaried GPs taking responsibility for leading on specific topics and issues. The lead GP for child safeguarding was a salaried GP and we found they were also the lead in this area of work for the CCG.

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 seven of these policies and procedures and found all seven had been reviewed annually and were up to date. Staff who preferred to access hard copies of practice policies knew that they were held in the practice manager's office in clearly marked policy files.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a lead GP for safeguarding. Other GPs took the lead for both management and clinical matters. For example one GP was lead for prescribing and there was also a lead GP for clinical governance matters. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Staff told us they felt valued, well supported in an inclusive environment and knew who to go to in the practice with any concerns. The leadership structure was displayed in staff areas. The GPs in the practice emphasised a strong focus on education, learning and continuous improvement for all staff and for patients to be supported appropriately. Some of the staff we spoke with described the practice as the best place they had worked.

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 discussed at monthly team meetings and the lead GPs for each QOF area produced plans 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, control of infection audits and a variety of audits linked to safe prescribing of medicines. We saw 13 audits had been undertaken in 2015.

The practice had arrangements for identifying, recording and managing risks. One of the senior GPs showed us the risk log, which addressed a wide range of potential issues. For example, the practice did not hold controlled drugs for relief of severe and chronic pain. We saw the register identified the availability of this medicine at the pharmacy next door to the practice. The risk log had been agreed by the partners. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, the risks associated with use of chemicals had been assessed and a control of substances hazardous to health (COSHH) file was held containing details of how to minimise risk from hazardous substances.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that complaints, significant events and risks had been discussed. We also saw that when the practice identified a rise in complaints relating to quality of consultations a training session was arranged. This enabled the more

Are services well-led?

Outstanding ☆

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

experienced GPs to mentor the team on good consultation techniques. The lead GP had reviewed complaints received since the training session and found no further complaints on this issue had been received.

Leadership, openness and transparency

The practice had a strong leadership structure. During the absence of a practice manager in post the managing partner GP had taken responsibility for day to day management of the practice. 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 open culture of the practice extended beyond the practice team. We found that significant events and presentation of rare clinical conditions were shared with two neighbouring practices. The extended hours clinics were also shared with another practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and the induction policy. The practice had a staff handbook that was available to all staff, which included sections on harassment and bullying at work. Staff we spoke with knew where to find policies if required.

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

The practice had gathered feedback from patients through reviewing the national patient survey data. Locally patient surveys were conducted with the patient participation group (PPG). There was a comments and suggestions box available by the reception and the practice reviewed the responses from patients who took part in the friends and family test (the friends and family test asks patients if they would recommend the practice and gives them the opportunity to comment upon the practice services). We looked at the results of the annual patient survey from 2014. This showed patients were generally satisfied with the care they received but only 17% of the 116 patients who responded said it was easy to get through to the surgery by phone. We saw as a result of this the practice had installed a new telephone system and monitored the waiting times for phone calls to be answered. The data showed that the average time for a call to be answered ranged from 49 seconds in June 2014 to two minutes 14 seconds in April 2015. The practice had increased the number of staff answering the phones between 8am and 9am, the busiest time of day, from three to six.

We reviewed the report of the PPG survey conducted in February 2015.This showed that 88 of the 100 patients who answered were either very satisfied or fairly satisfied with the care they received and 86 would be likely to recommend the practice. This showed a significant improvement on the results from the previous year. The practice had an active patient participation group (PPG) of seven members and this was enhanced by patients who contributed their views and comments on the service via e-mail contact. The 26 members represented a cross section of the practice population. The PPG had carried out annual surveys and met three or four times a year. We met three members of the PPG and they told us about some of the changes the practice made in response to patient feedback. For example, introducing online appointment booking. The PPG also held open evenings at which topics such as chronic diseases were discussed and patients could comment on the services they received. We also heard that the PPG was working on a project with Healthwatch Slough.

The practice had gathered feedback from staff through day to day discussions with line managers and GPs and from staff meetings. 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.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. However, one member of staff we spoke with was unclear about the terminology of whistleblowing and was not aware of the practice policy. They told us they would not hesitate to report any matters of unsafe practice they observed.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place. Staff we spoke with confirmed they received appraisals and that these took place every year. Staff told us that the practice was very supportive of

Are services well-led?

Outstanding ☆

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

training and we reviewed the training record which confirmed staff were active in taking up a wide range of training opportunities. For example, training in equality and diversity and in information governance. The training plan identified the varying levels of training each member of staff was required to undertake and all staff had access to an online training facility. Staff were encouraged to attend the training events held nine times a year when the practice received cover from the CCG. We also learnt that staff were given protected time to complete their online training courses.

The practice was a GP training practice and hosted up to four GPs in training at any one time. The GP National Training Scheme survey results for 2014 showed the practice was above average in two areas of training. The survey had been completed by the four trainees who worked at the practice in 2014. There was also evidence that the practice had accommodated GP trainees who required additional support. The practice was also hosting the placement of a trainee practice nurse. It supported the learning of this member of staff and allowed them time to attend relevant college training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and via staff information screens to ensure the practice improved outcomes for patients. For example, the system of displaying the patient to be called for their appointment was tightened up to avoid the patient's medical condition being displayed alongside their name.