Emmer Green 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?	Requires improvement
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

Emmer Green surgery is based in a purpose built practice that has been extended over the years as the number of patients increased. Over 9,000 patients are registered with the practice. We carried out an announced comprehensive inspection of the practice on 19 November 2014. This was the first inspection of the practice since registration with the CQC.

The feedback received from patients was positive. Patients spoke positively about the care they received and described the staff as caring. The practice results for the national GP patient survey 2013 mostly compared well with the clinical commissioning group (CCG) and national averages. The practice was aware the satisfaction rating for obtaining appointments was not as high as other practices in the area. Changes had been made to the appointment system and an additional clinic had been established in the last month.

We spoke with ten patients during the inspection. We met with two members of the patient participation group and spoke with six GPs and a range of practice staff.

Emmer Green Surgery was rated good overall.

Our key findings were as follows:

- the practice operates mostly safe systems. However, improvements must be made in the way medicines are managed.
- GPs treat patients in accordance with national and local guidelines. Staff are trained and knowledgeable. The practice works with other services to ensure patients with complex needs are cared for appropriately. We saw evidence of close working relationships with consultants in both psychiatry and diabetology that benefitted patient care.
- patients told us and we observed that they were treated with care and compassion.

Summary of findings

- the practice offers a range of appointment options and alternative means of booking appointments, including online booking.
- the practice is well led. Staff show a strong commitment to delivering patient centred care in a timely manner and are involved in planning services for the future.

We saw areas of outstanding practice including:

- patients with long term mental health problems who moved to other locations within Reading were able to remain registered at Emmer Green Surgery to support continuity in their care and treatment.
- an ear nose and throat (ENT) clinic was held at the practice by one of the GPs qualified in this specialty. Working with local commissioners enabled the practice to provide physiotherapy, talking therapies and speech and language clinics on site. This benefitted patients who found it easier to attend the practice rather than local hospital or clinics elsewhere.

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

Importantly, the provider must:

- introduce a system to confirm that actions required from national medicine alerts have been taken.
- ensure fridges holding vaccines and medicines required to be stored at a controlled temperature are locked when not in use.
- cease the practice of the health care assistant administering flu immunisations without prior written authorisation from an approved prescriber.

In addition the provider should:

- ensure practice nurses are familiar with the fridge failure protocol contained in the service continuity plan.
- improve the training of reception staff who occasionally carry out chaperone duties to ensure they are fully trained in this role
- provide updating training on infection control for the infection control lead and provide training in infection control to all staff appropriate to their role.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. The practice must improve the way in which medicines are managed. We found weaknesses in the medicines management systems that had not been addressed. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. With the exception of medicines management information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and were mostly managed. There were enough staff to keep people safe.

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 NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams and health visitors and district nurses updated patient records on the practice system. There was evidence of close working relationships with consultants specialising in care of the elderly and psychiatry benefitting the care and treatment of patients living in care homes and those with mental health problems.

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 said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Survey results identified nurses and GPs gave sufficient time for patients to discuss their care and treatment. Information to help patients understand the services available was easy available. 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

Summary of findings

services where these were identified. Patients said they found it easy to obtain an urgent appointment on the day they called. The practice had increased appointment availability and introduced a new telephone system to facilitate better phone access for patients.

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 with staff and other providers of care when appropriate.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a two year business plan and a caring ethos which all staff demonstrated. Staff were clear about the responsibilities of their role and the level of decisions they were able to take. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and to identify and manage risk. The practice actively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered personalised care to meet the needs of the older patients in its population. This included supporting patients in a local care home. End of life care was in line with national guidance and the practice worked with other care professionals to ensure the needs of this group of patients were met. It was responsive to the needs of older patients, and offered home visits and rapid access to telephone consultations for those with enhanced needs. Older patients who required assistance to book hospital appointments were supported.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. 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. Annual reviews of patients with more than one long term condition were coordinated to reduce the number of times the patient had to attend the practice. 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. There was an ear nose and throat (ENT) clinic held at the practice by one of the GPs who was trained in this branch of medicine.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. An audit of children attending A&E had been carried out and the practice shared the results via the patient website. Parents and guardians were encouraged to consult the practice GPs and nurses when children had minor ailments and minor injuries. Immunisation rates were high for all standard childhood immunisations. 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. Mother and baby health checks were offered and taken up. There was a system in place to follow up mothers who did not attend for these checks.

Summary of findings

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). Early morning and later evening appointments were available. Telephone consultations were available to support patients who found it difficult to attend the practice during working hours. Physiotherapy clinics and visiting talking therapy services were available at the practice which reduced the need to attend hospitals and clinics in other areas. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice performance in achieving successful taking of cervical smears was better than the national average.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice did not have many patients registered in this group. Registers of both carers and patients with a learning disability were in place. Information for carers was available both at the practice and on the patient website. A named GP was allocated for patients with a learning disability who lived in supported accommodation and these patients received regular health check-ups.

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). The national targets for supporting the physical health of patients with mental health problems had been met. Care plans were in place for patients with long term mental health conditions. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. Patients with long term mental health problems could remain registered at the practice if they moved to other areas of Reading. This supported continuity of care until the patient felt confident to register with an alternative practice closer to their new home.

The practice offered patients experiencing poor mental health advice on how to access various support groups and voluntary organisations. Leaflets about local support groups were available and referrals to the memory clinic for patients with dementia were made.

Summary of findings

What people who use the service say

The results from the most recent national patient survey showed patients to be mostly positive about the services they received from the practice. This was reflected by 93% of the 117 patients who responded saying that GPs were good at listening to them. This was 6% above the local CCG average. Patients who took part in this survey also rated the practice highly for nurses involving them in their care and treatment decisions and for GPs explaining test results. The responses to both of these questions were better than the CCG average. The practice was addressing the results which were less than positive. For example an additional GP clinic had been introduced to increase the number of appointments available and partitions had been placed between the reception desk and the waiting room to reduce the opportunity of patients in the waiting room overhearing conversations with reception staff.

The results from the last PPG and practice patient satisfaction survey were positive. We saw that concerns relating to the length of time it took patients to get through to the practice had been heard and addressed. A new telephone system had been installed in October 2014. The practice had also listened to patient concerns regarding access to GP advice and urgent appointments and had increased the number of book on the day appointments and telephone consultation appointments.

The ten patients we spoke with during the inspection and most of the 39 patients who completed CQC comment cards prior to our visit were also positive about the care and treatment they received from the practice. Patients told us they were treated with dignity and respect and felt involved in planning their care and treatment needs.

Areas for improvement

Action the service MUST take to improve

- introduce a system to confirm that actions required from national medicine alerts have been taken.
- ensure fridges holding vaccines and medicines required to be stored at a controlled temperature are locked when not in use.
- cease the practice of the health care assistant administering flu immunisations without prior written authorisation from an approved prescriber.

Action the service SHOULD take to improve

- ensure practice nurses are familiar with the fridge failure protocol contained in the service continuity plan.
- improve the training of reception staff who occasionally carry out chaperone duties to ensure they are fully trained in this role
- provide updating training on infection control for the infection control lead and provide training in infection control to all staff appropriate to their role.

Outstanding practice

- patients with long term mental health problems who moved to other locations within Reading were able to remain registered at Emmer Green Surgery to support continuity in their care and treatment.
- an ear nose and throat (ENT) clinic was held at the practice by one of the GPs qualified in this specialty.

Working with local commissioners enabled the practice to provide physiotherapy, talking therapies and speech and language clinics on site. This benefitted patients who found it easier to attend the practice rather than local hospital or clinics elsewhere.

Emmer Green Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a specialist practice nurse advisor and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

Background to Emmer Green Surgery

Emmer Green is a ward within Reading Unitary Authority. Over 9,000 patients are registered at Emmer Green Surgery. There are six GP partners at the practice who work the equivalent of 5.05 full time GPs. Three female and three male. A female GP assistant is also employed and is included in the 5.05 GP complement. A nurse practitioner leads the nursing team of four nurses and two health care assistants/phlebotomists (a phlebotomist specialises in taking blood tests for patients). The practice manager is supported by a team of administrative and reception staff. Services are provided via a personal medical services (PMS) contract held with the local team of NHS England.

Information available to the CQC showed the practice performed well in delivering the targets contained in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. National screening programmes, for example cervical screening and bowel cancer screening, are offered. The practice performance in promoting health screening compares well with other practices in the clinical commissioning group. The practice takes part in enhanced services for example, extended surgery hours are two mornings every week from 7.30am and on three evenings a month up until 8pm.

Services are provided from one location:

Emmer Green Surgery, 4 St Barnabas Road, Emmer Green, Reading, Berkshire, RG4 8RA

The practice has opted out of providing out of hours services to their patients. 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 website.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service on 19 November 2014 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 practice is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This practice had not been inspected before and that was why we included them

Detailed findings

How we carried out this inspection

Before visiting Emmer Green Surgery we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the North and West Reading Clinical Commissioning Group (CCG). We carried out an announced inspection visit on 19 November 2014. During our inspection we spoke with a range of staff, including GPs, practice nurses, the practice manager, a health care assistant (HCA) and reception and administration staff. We also spoke with health visitors who worked closely with the practice GPs and nurses.

We observed how patients were being cared for and spoke with ten patients. We reviewed 39 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit. Records relating to management of clinical conditions and others relevant to the management of the service were reviewed.

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)

Emmer Green Surgery has a wide ranging patient population. Fewer patients were registered from the 20 to 35 year old age group than other practices in the clinical commissioning group. The number of patients aged over 65 was slightly higher than the local and national average. The practice offered care and treatment to patients living in a local care home.

Requires improvement

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 when a patient returned a box of used needles and the box was overfull and had not been closed properly.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A formal review of significant events was conducted every quarter by the GPs. Newly reported incidents were discussed by the GPs at their weekly meetings. The nurses discussed significant events at their team meetings and kept records of their discussions. Reception and administration staff were informed of incidents and the learning from them when these were relevant to the whole team. The quarterly review of significant events did not include members of the nursing and administration staff. The practice did not operate a practice wide approach to reviewing and learning from significant events. Nursing staff we spoke with told us they would welcome the opportunity to work with the GPs in analysing and learning from significant events. Records showed the practice met the local target for reviewing an agreed number of significant events every year.

There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. We reviewed all the incidents for the last year and the records were completed in a comprehensive manner. Evidence of action taken as a result was shown to us. For example, the process to be followed if a blood test result for a patient registered at a different practice was received.

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 GPs, nurses and administration staff about their understanding of safeguarding. 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 including where to locate the contact details of the relevant agencies. These contact details were held on an easily accessible file on the practice computer system.

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 (e.g. level 3). All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example patients with mental health problems that required immediate telephone support or access to an appointment.

There was a chaperone policy, which was visible near the reception desk. All nursing staff, including health care assistants, had been trained to be a chaperone. We were told that on rare occasions receptionist staff had undertaken chaperone duties. These staff told us they had been given guidance on the role by the GPs. However, we found these staff were not trained in where to stand to be able to observe the examination and had not been subject to a criminal records check. The practice had conducted a risk assessment concluding that chaperones were never left in the consulting room alone with a patient.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. Medicines stored in treatment rooms were stored securely and only accessible to authorised staff. However, a vaccine fridge kept in a room which led to a fire exit did not lock and the door to the room had to be left unlocked because it was on a fire exit route. These medicines were not held securely and could have been accessed by patients or others visiting the practice. There was a clear policy for ensuring that medicines were kept at the required temperatures. There was a further policy which described the action to take in the event of a fridge failure which formed part of the practice service continuity plan. Practice nurses were

responsible for the safekeeping and management of medicines. Those we spoke with described the procedure they would follow if a medicines fridge failed. The actions they described followed good practice. However, they were unaware of the practice policy contained in the service continuity plan.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with 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 the directions to be followed by practice nurses and evidence that they had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and they received updates specific to the clinical areas of expertise for which they prescribed.

The health care assistant (HCA) had been appropriately trained and qualified to administer flu immunisations and we saw the directions that were to be followed when this member of staff administered this immunisation. However, the direction was not followed for every immunisation. We found the HCA on occasions administered the vaccine to eligible patients before an approved prescriber had signed the written authorisation. Appropriate authorisation was therefore, obtained retrospectively. We informed the practice manager and senior nurse that this process did not follow legal requirements and should be ceased.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. We noted that the responsibility for reviewing some of these medicines such as blood thinning agents and medicines used in the treatment of rheumatoid arthritis was undertaken by the local hospital. GPs held responsibility for prescribing these medicines on the advice of hospital colleagues.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were received safely and stored securely.

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

There was evidence of close working with pharmacists from the CCG medicines management team. We saw these officers visited the practice regularly and worked with GPs to optimise use of medicines. We saw the practice had achieved 90% of the local medicines quality and productivity targets in the previous year. Targets achieved included carrying out an audit and meeting the targets for appropriate prescribing of four specialist antibiotics. We saw that members of the medicines management team discussed medicines management issues with the GPs. Their support was used when CCG initiated changes in medicines were required and they audited practice conformity when changes were made. GPs received direct notification of national alerts regarding medicine safety. These included advice on changing dosage of medicines and when medicines needed to be stopped or monitored more closely. GPs we spoke with told us how they responded to these alerts but there was no evidence of a system to check that all GPs had completed the action required from the alert.

Cleanliness and infection control

The practice was clean and tidy on the day of our inspection. The practice manager and nursing staff we spoke with told us they found cleaning standards were maintained to an appropriate standard. There was a cleaning specification that set out each cleaning task required and the frequency upon which the task needed to be completed. Monitoring was undertaken by completion of checklists and we saw these were used. Cleaning materials were stored safely and were colour coded to ensure separate equipment was used in clinical and non-clinical areas. The cleaning products used were stored in a locked cupboard and there was a record of the safety instructions for each product used. This included how to use the product safely and the measures to take in the event of a spillage of an undiluted cleaning product. 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. This member of staff had undertaken further training in 2013 to enable

them to provide advice on the practice infection control policy. Refresher training had not been undertaken in the last year. There was no evidence to show staff received induction training about infection control specific to their role. We saw evidence that audits of infection control processes and the practice environment had been undertaken in the last two years. The practice had an infection control policy. However, the policy referred to a thorough programme of infection control training through induction which could not be evidenced from discussions with staff or from induction records.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

There were detailed records confirming that equipment had been maintained and serviced in accordance with manufacturer's instructions. Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Records demonstrated that electrical equipment had been tested at appropriate intervals to ensure it was safe to use. The main services and fixed equipment to maintain the safety of the practice had been appropriately maintained. The central heating boilers had been serviced and gas safety certificates issued. Fixed wiring in the practice had been tested and passed safe. When work was required to maintain these services it had been undertaken promptly. The test reports and invoices we saw evidenced this. There was also evidence that firefighting equipment and the fire alarm system were serviced on an annual basis and we saw that fire extinguishers and fire blankets were held in appropriate locations throughout the practice.

Staffing and recruitment

We reviewed seven staff personnel files. These contained evidence that the majority of appropriate recruitment checks had been undertaken prior to employment. For example references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Staff we spoke with told us they had provided proof of identity prior to starting with the practice and that this was checked a second time on the day they commenced work. We informed the practice manager that copies of proof of identity were not held on file. Continued membership of professional bodies was checked on line. We saw a record of the nurse's registration details. The practice had a recruitment policy that set out the standards it followed when recruiting all grades and disciplines of staff.

There was a rota system for all the different staff 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. The practice recognised that more staff were needed during busy periods of the day. We saw that more staff were on duty in the morning when demand was higher than in the afternoon.

On occasions when the practice required the services of locum GPs these were known to the practice and had appropriate checks carried out before they undertook any duties.

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, and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see. Staff we spoke with told us they would report any health and safety matters to the practice manager or the lead nurse.

The practice health and safety policy was supported by a range of risk assessments. For example, fire risk assessment and manual handling assessment. Safety instructions and procedures were also included in the staff handbook.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff received annual training in basic life support. Recently appointed staff were aware of the requirement to attend this training and we saw that the training session for 2015 had been booked. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to

Requires improvement

Are services safe?

attempt to restart a person's heart in an emergency). Staff we spoke with knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency relating to the use of the defibrillator and that practice had learned from this appropriately.

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 service continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each potential emergency was described and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, boiler failure, flood and incapacity of staff. 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. The steps to follow when reviewing patients' care were included in templates on the computerised patient care record.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. The lead GP in diabetes management and the diabetes nurse met fortnightly to discuss the care and treatment of diabetic patients with complex needs. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. For example, GPs would seek advice from the GP with additional training in ear nose and throat (ENT) conditions when patients with complex ENT conditions attending for an appointment. Nurses told us they could obtain advice from GPs promptly. Our review of clinical meeting notes showed that GPs discussed specific medical conditions and supported each other in following clinical guidance.

Data from the local CCG showed us the practice's performance for antibiotic prescribing was comparable to similar practices.

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 for example child protection alerts. Annual reviews for patients with long term conditions or requiring review of their repeat medicines were schedule into the patient records.

The practice showed us 21 clinical audits that had been undertaken in the last three years. Seven of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example the practice had completed audit cycles on referrals of patients for joint replacement. The second audit cycle showed all referrals followed the local referral protocol. Other examples included audits to confirm that a GP who undertook cervical cytology achieved successful results from all cervical smears taken. There were also single audits that had resulted in no further action. For example an audit of home visits undertaken had shown all were appropriate. There was documented evidence of six audits being discussed with other GP practices from the CCG. This enabled sharing of outcomes and benchmarking against other practices.

We evidenced that clinical audits were often linked to medicines management information or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, an audit of insulin used in treating patients with diabetes. Data relating to successful taking of cervical smears showed the practice performed better than the national average.

There was an audit of attendances of children at A&E. This identified that over 50% of the conditions which children attended for could have been treated at the practice. The patient website and information displayed in the practice gave advice to parents on the services the practice was able to offer children. The information encouraged parents to approach the practice, during opening hours, before taking children to A&E.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, over 90% of the targets for managing patients with diabetes had been met. All the minimum standards for QOF in asthma and chronic obstructive pulmonary disease had been met The practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. Staff responsible for the printing of repeat prescriptions were aware of the protocol and the practice had a system to remind patients their prescription review was due. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. GPs told us how

Good

Are services effective?

(for example, treatment is effective)

valuable this was. There was evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question. However, completion of action was not co-ordinated.

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. The practice also held a register of patients with a learning disability. The practice had very few patients registered in this group. These patients were offered an annual physical health check-up. The named GP for patients with a learning disability who lived in supported accommodation administered flu immunisations at the patient's home to ensure they received this important immunisation. This also assisted these patients who found it difficult to attend the practice.

Doctors in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date.

Effective staffing

Practice staff included GPs, nursing, managerial and administrative staff. We were given a copy of the staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the GPs with three having additional diplomas in child health and four with diplomas in obstetrics and gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs. Discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, eight members of administration staff had completed training in equality and diversity during 2014. Staff we spoke with told us how they took part in, and valued, training provided by the local clinical commissioning group (CCG). We saw that a recent CCG training event had focussed on safeguarding and child protection.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and undertaking cervical cytology tests. One member of the nursing team was qualified as a prescriber and we saw their training to maintain this status was up to date. Nurses were also trained to support patients with long term conditions such as Asthma and Diabetes. We spoke with these nurses and they demonstrated their knowledge and expertise in managing these conditions. We heard that the practice had, in early 2014, identified patients with more than one long term condition and were now co-ordinating the health reviews for this group to reduce the number of times the patient needed to attend the practice.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage the needs of patients with complex medical conditions. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received electronically. Urgent communication was received by fax. Communication with hospitals and services in other areas was sent by post or fax. Designated members of the administration staff held responsibility for ensuring communication from hospitals was passed to the GPs on the day they were received. GPs reviewed these communications each day and there was a system in place whereby each GP had a 'buddy' to review communications in their absence. The GP seeing these documents and results was responsible for the action required.

The practice held multidisciplinary team meetings at least six times a year. The care and treatment of patients with complex needs was discussed at this meeting. This included those identified as requiring end of life care (as part of a national programme called the gold standards framework). The meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented and circulated to all who attended. Staff we spoke with felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. Meetings were also held with the health visitors to discuss children at risk.

A number of residents at a local care home were registered patients of the practice. These patients received an annual review of their care needs when the one of the GPs

undertook a joint ward round with the local consultant in elderly care. This review was in addition to the regular attendance of the GPs to support these patients' day to day care. There was evidence of close liaison with local services supporting patients with mental health problems. A quarterly meeting was held with the consultant in psychiatry and GPs described positive experiences of working with the community mental health team. We also heard how the relationship with the local child and adolescent mental health services had benefitted patients. We were given examples of young patients receiving an assessment by the professionals in this team within 24 hours of the GP contacting the team to refer a patient. A 'virtual' diabetes clinic was held every three months enabling the GPs to discuss the care and treatment of patients with diabetes with the consultant who specialised in the care of diabetes.

Information sharing

The practice used electronic and manual systems to communicate with other providers. For example, there was a system, called patient notes, with the local 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 all referrals to local hospitals through the Choose and Book system. (The Choose and Book system enabled patients to choose which hospital they wished to be seen in and to book their own outpatient appointments in discussion with their chosen hospital). We heard that some GPs supported patients by commencing their referral during the consultation. When a referral letter was dictated the urgency was indicated to the secretary who had the responsibility to process the referral letter. Referrals for urgent treatment within two weeks were also processed through this system. Staff we spoke with were knowledgeable in the use of choose and book and gave us examples of how they had supported some elderly patients to make their hospital appointments.

The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information). Medical data (for example, record of allergies) would be securely shared, for those patients who had consented, with other providers of health care to support delivery of emergency care. For example, when a patient attended a hospital A&E department.

The practice had a system in place to provide staff with the information they needed. An electronic patient record EMISWeb was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved on the electronic patient record for future reference.

We spoke with the local health visitors during the inspection. They described good working relationships with the practice and told us regular meetings with the GPs took place to discuss and plan the care for children identified as at risk. There were offices at the practice allocated for the use of the health visitors and district nurses. Both groups of staff were able to access the electronic records of patients they were delivering care and support to and were able to add entries to patient records to keep GPs up to date with their involvement. We were told how helpful this was in informing practice staff of the progress of patients receiving care from both the health visitors and district nurses.

Consent to care and treatment

We found that GPs and nurses were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. GPs we spoke with gave us examples of how they applied the legislation. There was a mental capacity assessment guide and checklist held on the practice computer system for GPs and nurses to refer to. The GPs we spoke with demonstrated a clear understanding of Gillick competencies. (These help GPs and nurses to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). GPs were aware that the competency principle would not be applied to a patient under the age of 13. The practice consent policy made specific reference to Gillick competencies and was available as a guide to both GPs and nurses.

There was a practice policy for documenting consent for specific interventions. For example, written consent was sought for minor surgical procedures. The practice also sought written consent from parents for children to receive their childhood immunisations.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice had numerous ways of identifying patients who needed additional support in maintaining a healthy lifestyle, and were pro-active in offering additional help. The practice had identified the smoking status of 87% of patients over the age of 16 and actively offered smoking cessation advice to 82% of those who smoked. Some of the patients we spoke with told us they had received smoking cessation advice and had taken up the opportunity to attend smoking cessation clinics. Over 83% of patients with Asthma received smoking cessation advice. Similar mechanisms of identifying at risk groups were used for patients who were obese. Staff told us that these patients could be referred for advice on healthy eating and for exercise advice.

The practice took part in the national chlamydia, mammography and bowel cancer screening programmes. There was evidence that they were the top performer within the CCG for take up of bowel screening in 2013 The practice had received an incentive award from the CCG for improving uptake by more than 3% in that year. There was a system to follow up patients who did not attend these screening programmes. Patients we spoke with told us GPs had explained the benefits of this programme and encouraged take up of the screening opportunity. We saw chlamydia screening was promoted via posters and leaflets and that testing kits were available.

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 childhood immunisations was above the national target of 90%. The practice achieved the highest rate within the CCG for immunisation of children at 24 months old. Data showed us that over 80% of patients diagnosed with chronic obstructive pulmonary disease (lung disease) had received a flu immunisation in 2013. Active promotion of flu immunisation took place and we saw posters and promotional material throughout the practice. There was evidence that flu immunisations were given by GPs during consultations to ensure the patient did not miss this important immunisation and to avoid the patient having to return to a flu immunisation clinic.

A wide range of health promotion material was available in the practice waiting room and via the website. The website contained a page entitled 'Family Health and a link to NHS choices 'live well' information. The family health pages on the website included sections specific to the needs of different patient populations registered. For example, there was a section dedicated to child health for six to fifteen year olds and another section on sexual health.

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, a survey of 406 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The last national patient survey results showed 117 patients out of 257 who were sent the questionnaire responded. The results showed satisfaction with consultations with GPs and nurses. Ninety three per cent of the respondents said the GP was good at listening this was above the average score for the clinical commissioning group. The responses to the question whether GPs and nurses treated the patient with care and concern were also above the local average. Seventy nine per cent rated nurses as good or very good for this measure and 89% rated the GPs as good or very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 39 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a caring service and that GPs and nurses efficient and helpful. Both the national survey and the patient participation group survey showed patients were concerned about the level of privacy offered at the reception desk and in the waiting room. We saw that the practice had positioned free standing partitions to separate the reception desk from the waiting room. The action plan from the patient survey showed the practice was seeking a more permanent solution to this issue. Three comments were less positive but these related to access to appointments. We also spoke with ten patients on the day of our inspection. All told us they were very satisfied with the care provided by the GPs and nurses and that they were treated with dignity and respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We observed that both 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. The practice switchboard was located away from the reception desk in a separate office. Calls from patients wishing to book appointments or discuss their care and treatment were not taken at the reception desk. We spoke with four members of the reception team about how they prioritised booking appointments for patients who wished to be seen on the day they called for an appointment. All four members of staff told us they followed a protocol for assessing urgency which involved asking the patient for a brief description of the issue they wished to see the doctor about. We were told how this ensured patients received timely care and treatment and enabled advice to be given to patients whose condition might require emergency treatment. If a patient did not wish to discuss their medical condition this was respected and their appointment was booked without further question.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 81% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG and national results. We also found that patients rated the practice nurses highly in these measures. Sixty seven per cent felt the nurses were good at involving them in decisions about their care and 78% rated the nurses as good or very good for explaining results of tests. This was also above the average for the CCG.

The ten 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. Similar views were reflected by patients who completed comment cards. They also told us they did not feel rushed during consultations

Good

Are services caring?

which gave time to consider the choice of treatment they wished to receive. We were given examples by patients of the GPs giving time to answer a range of questions about treatment and options. For example, about pregnancy and also the options for surgery.

Data showed us that all patients with long term mental health conditions had a care plan that had been agreed with them. There were also care plans in place for patients receiving end of life care and for patients with a learning disability. Care plans had been developed and agreed with patients with a higher risk of being admitted to hospital.

Staff told us that translation services were available for patients who did not have English as a first language. One of the GPs spoke Polish and we were given examples of Polish patients receiving their care and treatment from this GP. The practice website carried a facility to translate information into 80 different languages.

Patient/carer support to cope emotionally with care and treatment

The responses on comment cards we reviewed told us that staff offered compassionate support to patients when needed. We heard that patients could be accompanied by a relative during a consultation if they wished and that chaperones were available to support patients during examinations and treatment. We saw parents accompanying children to their consultation. Patients we spoke with were positive about the compassionate support they received from the GPs. This included examples of referring patients to other professionals and following up the advice these professionals had given with the patient. There were further examples of family members being given bereavement support after the death of a relative.

Notices and leaflets in the entrance lobby, information on the TV screen in the waiting room and information on the patient website also told people how to access a number of support groups and organisations. The practice held a register of patients who were also carers and we saw that information for carers was available in the entrance lobby. For example, information on local carer support groups. When carers could not attend the practice they were offered home visits. We heard how elderly patients finding it difficult to make appointments at hospital were given support to do so by the medical secretaries. We also heard that on occasions staff had made the appointment on behalf of the patient with the patient's consent.

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 people'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.

The North and West Reading Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. An audit showed us the practice had engaged in the review of referrals for joint replacements. The results evidenced that GPs had followed the local referral protocols. One of the GPs was a member of the CCG board and brought issues back to the practice for discussion with colleagues. The practice ensured that patients who had been discharged from hospital were appropriately referred to the local reablement team to reduce the risk of re-admission to hospital.

A range of clinics and services were offered to patients, which included family planning, antenatal, children's immunisation and minor illness. The practice ran regular nurse specialist clinics for long-term conditions. These included diabetes and coronary heart disease clinics. Longer appointments were available for patients if required, such as those with long term conditions. GPs placed all new patients who were diagnosed with long term condition on practice register and organised recall programmes accordingly. We saw minutes of meetings that identified patients likely to develop diabetes in readiness to commence comprehensive reviews that incorporated all aspects of an annual diabetic health screening.

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). For example, there was evidence of promoting booking of appointments online.

Tackling inequity and promoting equality

The practice recognised the needs of their patients. A translation service was available. Patients whose first language was not English could bring a relative or friend with them to their appointment to translate for them if they preferred. An induction loop system was available to support patients with a hearing impairment (an induction loop amplifies voice to assist patients using a hearing aid). Written information could be made available in large print for patients with a visual impairment.

All patients living in a local care home, those with a learning disability and patients with long term mental health problems had a named GP to support their needs and develop care plans with them.

A carers' register was in place. Carers could request a home visit if they found it difficult to leave the person they cared for. Information on support services for carers was provided via leaflets in the entrance lobby.

All consulting and treatment rooms were located on the ground floor. The practice had wide corridors enabling access for wheelchairs and mobility scooters. This made movement around the practice easier and helped to maintain patients' independence. There was a ramp to the practice entrance and automated doors enabled access for patients who were frail or had mobility problems.

The practice had an open registration policy enabling everyone who lived within the practice area to register as a patient. Patients with long term mental health problems who moved out of the practice area to other locations within Reading were able to maintain their registration to assist with their ongoing care and treatment. This continued until such time as the patient felt confident to register with another GP practice.

Access to the service

Appointments were available from 8:30am to 5.30pm on weekdays. The practice was open until 6.30pm with GPs on site to deal with urgent patient needs. Early morning appointments were available on two mornings each week from 7.30am. Later evening clinics were held on three evenings every month with appointments scheduled until 8pm. The practice did not close during lunch time and urgent treatment could be accessed during this time.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an

Good

Are services responsive to people's needs?

(for example, to feedback?)

answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was displayed on notice boards and detailed on the patient website.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a local care home as and when the patients living there required care and treatment. The patients at the care home had a named GP to ensure continuity of care.

Patients were generally satisfied with the appointments system. 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. The practice was aware of comments from patients that were not so positive about booking appointments in advance and being able to get through on the phone to book an appointment. We saw that an additional GP session had been added each week and that the telephone system had been changed on 1 October 2014 to improve access.

The practice's extended opening hours on two mornings a week and three evenings a month were useful to patients with work commitments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for ensuring all complaints were dealt with in accordance with the practice policy.

Information was available to help patients understand the complaints system. A poster setting out how to make a complaint was displayed on a notice board. We asked some staff how they would support a patient wishing to make a complaint. They were able to tell us about the complaints procedure and how they would try to seek a prompt resolution for the patient by referring them to the practice manager. The complaints procedure was detailed on the practice website and in the patient information leaflet. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the complaints log for 2014. This contained 10 complaints received between January and October. All complaints had been dealt with in accordance with the practice complaints procedure. The complaints had been acknowledged, investigated and responded to in a timely manner. We saw that when a complainant was unhappy with an initial response the matter was referred to the designated GP dealing with complaints who resolved the patient's concerns.

The practice reviewed complaints annually. Individual complaints received were discussed at practice meetings in the month they were received. We saw a summary of the complaints review carried out in 2013. This showed 11 complaints had been reviewed. Learning from individual complaints was disseminated to staff via their line managers.

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

The practice charter was displayed and was available on the patient website. Values included in the charter included the targets for seeing patients on time and ensuring services were accessible to all. Staff we spoke with demonstrated commitment to the values included in the charter. We saw that an audit had been carried out to review the length of time patients waited when attending for their appointments and that GPs had recognised the need to avoid keeping patients waiting. Reception staff we spoke with told us how they offered appointments to all patients who requested to be seen or receive a telephone consultation.

There was a practice two year business plan. This set out the practice aims and objectives for the period and included reference to the services offered and the resources required to maintain and improve the care and treatment for patients. There was a formal consultation system to involve staff in the preparation of the plan. Staff were surveyed via a questionnaire to obtain their views on the direction the practice could take and what could be included in the plan. When completed the business plan was shared at staff meetings held during CCG learning sessions.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a file held on the practice computer system. Key policies and procedure were contained in the staff handbook and we saw staff had confirmed they had received and understood the handbook contents. We looked at eight of these policies and procedures. All of the policies we looked at had been reviewed annually and were up to date.

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 the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

There was a named member of staff responsible for security and appropriate use of patient information. The practice had quality assured the processes for security of records by completing an annual nationally approved audit.

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 audits of successful taking of cervical cytology tests were undertaken annually and the results reviewed to maintain good performance.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

Staff were kept informed of important issues via their line managers and through systems of team briefings and team meetings. The GPs met every week. Practice nurses held meetings every one to two months and we saw that training and clinical updating were regular topics of discussion. The administration and reception staff used the seven CCG learning sessions held during the year for their team meetings. Full practice team meetings were held twice a year during CCG learning sessions. Staff we spoke with told us they felt confident in taking matters to their line manager or the practice manager in the knowledge they would be listened to. All staff we spoke with told us the GPs were approachable and listened to staff ideas and concerns. Practice nurses were positive about the day to day working relationships they had with the GPs. However, they told us they would welcome the opportunity to meet more regularly with the GPs in a practice clinical team setting.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example induction policy and the recruitment policy which were in place to support staff. We saw a staff handbook was available to all staff. This included sections on equality and harassment and whistleblowing. Staff we spoke with knew where to find these policies if required and we saw that staff were required to formally acknowledge updates to the personnel policies and procedures.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through patient surveys, complaints received and from meetings with the patient participation group (PPG). We looked at the action plan resulting from the last patient satisfaction survey carried out by the PPG and the practice. This showed us that 23% of patients found it difficult to get through to the practice by telephone. The practice had responded to this by installing a new telephone system. This increased the number of lines available and offered a call waiting function. We were told it was too early to evaluate the new system and measure the improvements for patients.

The practice had an active patient participation group (PPG) which met regularly. Meetings were held in the evening to enable patients of working age to attend. PPG members we spoke with told us they felt the practice listened to the views of patients and acted upon them. The practice provided us with an analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from the survey were available on the practice website.

The practice gathered feedback from staff through staff meetings and appraisals. Staff were able to contribute to planning practice services by completing a questionnaire when the practice business plan was in preparation stage.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with their line manager, practice manager or one of the GPs. 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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at seven staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they valued the opportunity to train together when the CCG organised half day training events.

The practice had completed reviews of significant events and other incidents and these were shared with staff via their managers and at staff team meetings. The nurses we spoke with told us that they would welcome the opportunity to meet with the GPs to review significant events and complaints. We saw that two recent significant events were scheduled for practice wide review at the next CCG half day training due to be held in late November.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Management of medicines.** **The registered person had not protected users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activities.** **Regulation 13.**