Hungerford Surgery

Quality Report

The Croft
Hungerford
Berkshire
RG17 0HY
Tel: 01488 682507
Website: www.**hungerfordsurgery**.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hungerford Surgery on 23 June 2015. This was the first inspection of this practice.

The practice is adapting and changing having appointed new staff after a long period of stable staffing. Two new practice nurses joined in 2014 and the practice is awaiting the arrival of a new GP partner starting in July 2015. In addition plans are being made for the retirement of the senior partner and for the recruitment of a replacement.

Overall the practice is rated as good. The practice is rated as good for the delivery of safe, effective, caring and responsive services. The practice requires improvement for being well led. The practice is rated as good for delivery of care to the population groups of older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- The practice was responsive to patient demand for appointments. Feedback from patients was positive in this area and patients said they did not wait too long to be seen. Extended hours clinics were available every other Tuesday and on Saturday's.
- The practice was clean and tidy and the staff paid attention to reducing the risks of cross infection.
- Patients who were carers and those living in care homes received high levels of care and support. Care plans were in place for patients in care homes and a flexible appointment system was in place for patients with caring responsibilities.
- The practice prescribed medicines in line with best practice. Medicines and prescriptions were kept securely and managed appropriately.
- Patient feedback from national surveys and patients we spoke with showed a high level of satisfaction with reception staff who were described as friendly and caring.

Summary of findings

- The GPs and management responded when they identified the practice could further improve services. For example an additional member of staff had been recruited to manage expansion of services and monitor the care of patients with long term conditions.

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

Importantly, the provider must:

- Operate consistent management processes to ensure all staff receive annual appraisals. Adequate levels of support and training relevant to their roles must also be delivered. For example, training in carrying out chaperone duties and in application of the Mental Capacity Act (2005).

In addition the provider should:

- Further improve the care of patients with long term conditions by operation of robust recall systems ensuring as many patients in this group as possible receive their annual reviews and treatment monitoring.
- Improve health promotion achievements by increasing the uptake of cervical screening, identifying the smoking status of more patients over the age of 16 and increase smoking cessation advice to those who smoke.
- Ensure all health and safety risks are identified and appropriate risk assessments completed. For example, a risk assessment of substances hazardous to health.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Most risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Some improvements could be made in the provision of services to patients with long term conditions and in achieving health promotion targets. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. GPs understood their roles in assessing capacity and promoting good health. Staff were receiving training appropriate to their roles but some additional training in chaperone duties and application of the Mental Capacity Act (2005) was required. There was evidence of appraisals for the majority of staff and training plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice similarly to 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. Information for patients about the services available was easy to understand and accessible. 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. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat

Summary of findings

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.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a vision and a strategy and staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and most staff felt supported by management although some staff had not received annual appraisals. A staff meeting structure was in place but meetings for the administration and reception staff were infrequent. Risks to health and safety were assessed and procedures were in place to reduce risks but, further improvement was required. The practice had a number of policies and procedures to govern activity and these were reviewed and updated at regular intervals. The practice was making significant effort to form a patient participation group but means of obtaining patient feedback at a local level was limited.

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. The practice recognised their performance in national quality standards for this group was below average and had taken action to improve. There had been a six percentage point improvement between 2014 and 2015. Some structured annual reviews had not taken place in the past to check that patient's health and care needs were being met. The practice had put new systems in place to ensure the reviews were undertaken.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children on the at risk register. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of

Summary of findings

care. The practice was proactive in offering online services. A range of health promotion and screening was available but take up of cervical screening and smoking cessation opportunities was below the local average.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including carers and those with a learning disability. It had carried out annual health checks for all patients with a learning disability. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including those with dementia). These ratings apply to all population groups. All patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Diagnosis rates of dementia were similar to the national average.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Patient feedback, from a variety of sources, about Hungerford Surgery was generally positive. Although we noted that the results of the National Patient Survey, in relation to care and compassion, carried out between July to September 2014 and January to March 2015 showed a small decrease in satisfaction compared to the results from earlier in 2014. The survey was completed by 123 patients. The practice was experiencing a period of change in early 2015 when a GP left and there was a gap before the new GP started. However, patients remained positive about access to services and the practice scored better results, for this aspect of service, than others in the area. For example:

- 86% of patients said the GPs were good at giving them enough time compared to 88% in the CCG and 87% nationally
- 81% of patients said the GPs were good at involving them in decisions about their care and treatment compared to 83% within the CCG and 81% nationally
- 79% of patients said they were usually able to speak to their usual GP compared to the CCG average of 67% and national average of 60%
- 86% said they usually waited less than 15 minutes or less after their appointment time compared to 64% average in the CCG and 65% nationally.

The practice was also taking part in the national friends and family test which asked patients if they would recommend the practice to others. The results from January to March 2015 showed 86% of respondents would recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Operate consistent management processes to ensure all staff receive annual appraisals. Adequate levels of support and training relevant to their roles must also be delivered. For example, training in carrying out chaperone duties and in application of the Mental Capacity Act (2005).

Action the service SHOULD take to improve

- Further improve the care of patients with long term conditions by operation of robust recall systems ensuring as many patients in this group as possible receive their annual reviews and treatment monitoring.
- Improve health promotion achievements by increasing the uptake of cervical screening, identifying the smoking status of more patients over the age of 16 and increase smoking cessation advice to those who smoke.
- Ensure all health and safety risks are identified and appropriate risk assessments completed. For example, a risk assessment of substances hazardous to health.

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

Background to Hungerford Surgery

Hungerford Surgery is located in a purpose built medical centre. The practice serves the population of the town of Hungerford and residents of neighbouring villages. There is a registered practice population of approximately 7,500. The practice is close to the border of the counties of Berkshire and Wiltshire and patients may choose to use other services in either county.

At the time of inspection there were four partner GPs. A fifth partner was due to start in early July 2015. The practice employs two practice nurses and two health care assistants (HCA'S). GPs and nurses are supported by a team of management and administrative staff. Upon appointment of the fifth partner there will be three female and two male GPs at the practice. The practice is approved as a training practice to support qualified doctors who are in their final year of training to become a GP.

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

The practice treats patients of all ages and provides a range of medical services. The practice population has a slightly higher proportion of patients aged 40-65 compared to the national average. There is minimal deprivation according to national data.

The practice is open between 8.30am and 6.30pm Monday to Friday. Appointments are between 8.50am to 12.30pm every morning and 2pm to 6pm daily. Patients in urgent need of an appointment can be seen throughout the day by a duty doctor and extra appointments are added if necessary. Extended hours surgeries are usually offered every other Tuesday from 7:15am to 8:15am and on Saturday's between 8.30am and 12:30pm. Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for the doctors and for the nursing clinics.

This is the first inspection of Hungerford Surgery and it was carried out as part of the CQC's planned inspection programme.

Services are provided from: The Croft, Hungerford, Berkshire, RG17 0HY

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

The practice is in the process of registering a new Registered Manager to take responsibility for the delivery of services as is required by the Health and Social Care Act (2008).

Detailed findings

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 Newbury and District Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Hungerford Surgery. Neither organisation provided any information specific to the practice. 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 23 June 2015. We spoke with 10 patients, four GPs and nine staff. We reviewed five CQC comment cards that had been completed in the two weeks prior to our inspection. As part of the inspection we met with the practice manager and looked at the management records, policies and procedures.

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

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The records of the six significant events that had occurred in the last year were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, when a patient with chest pain was given an appointment at the practice staff were retrained to advise patients with chest pain to call for an ambulance. When staff members reported a significant event it fed through to the agenda on the next practice clinical meeting. Significant events were a standing item on the agenda and a dedicated meeting was held once every six months to review actions from past significant events and complaints.

There was evidence that the practice had learnt from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. For example, when an incident had been recorded regarding entitlement to NHS services for a patient from overseas the practice took action to ensure more than one member of staff was trained in registration of overseas visitors.

National patient safety alerts were disseminated to GPs and practice nurses. The GPs reviewed the implications of alerts at clinical meetings and set action plans to deal with the alert. For example, when an alert was received relating to a specific medicine the practice ran a search of patients taking the medicine and GPs called the patient to agree any changes required. If the alert related to medical or general equipment the practice nurses or senior administration staff took relevant action to ensure equipment remained safe for use.

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, practice nurses 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 and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a GP as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with 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 children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and was on the practice web site. (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). However, the chaperone policy or notices advising chaperones were available were not displayed in consulting rooms or treatment rooms. All nursing staff, including health care assistants, were nominated as chaperones. However, some of these staff were not clear on their role in undertaking this duty because they had not received training in the role. For

example, where to stand to be able to observe the examination. Not all staff undertaking chaperone duties had Disclosure and Barring Service (DBS) check in place at the time of inspection. However, we saw evidence that the check had been applied for and the practice had a policy detailing the action it would take if a member of staff was found to have a criminal conviction or had been barred from working with children or vulnerable adults. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines kept in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. We checked 16 medicines and all were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as blood thinning medicines and disease modifying medicines, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. The practice undertook all monitoring of blood thinning medicines locally and there had been no incidents reported of missed results or failure to take action on results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The PGD's we reviewed were all current and none expired until the end of July 2015 at the earliest. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

The practice prescribing data we reviewed showed the practice performing well in reducing the use of medicines which research showed may on occasions not be effective. For example, prescribing of antibiotic medicines was lower than the national average. The practice also took part in the local CCG prescribing management scheme and we saw they achieved 96% of the prescribing targets in 2014. Minutes of clinical meetings showed that the GPs discussed best practice in prescribing on a regular basis. For example, when the CCG medicines management team proposed medicine changes these were discussed by GPs before the changes were made.

The practice held a small stock of one type of controlled drug (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had procedures in place 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 safe and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Cleanliness and infection control

We observed the premises to be generally clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. We found two consulting rooms where the standards of dusting could be improved. We advised the manager responsible for the cleaning contract of our findings and they noted the issue to refer on to the cleaning contractors. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a lead for infection control to enable them to provide advice on the practice infection control policy and carry out staff training. The practice ensured all staff were briefed on the infection control policy and were aware of their responsibilities to reduce the risk of cross infection. For example, reception staff were able to describe their role in safe receipt and handling of specimens. We saw evidence

that the Infection Control Lead had carried out an infection control audits in 2014 and had involved the CCG lead for infection control to provide expert input to the process. We saw there were few points to action and those that were identified had been completed since the last audit.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, when assisting GPs with minor surgical procedures. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of such an injury. The policy was displayed in both consulting and treatment rooms.

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

The practice had completed a risk assessment in 2015 to assess the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was June 2015. 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.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. 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. Criminal records checks with the Disclosure and Barring Service (DBS) (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable) had not been completed for health care assistants who were in post before April 2013. We saw evidence that these had been applied for and were awaited. One member of the practice nursing team had a DBS disclosure from their previous GP practice. The practice had applied for a further check. The practice had a policy which set out the actions they would take if a member of staff had a conviction or a barring order. This included informing the relevant professional body in the case of a GP or practice nurse.

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 and we saw that the practice was actively training staff to cover more specialist duties. For example, a member of staff was in training to undertake medical secretary duties. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We found that the practice took action when they identified shortfalls in staffing or the need to expand or change roles. For example a patient services officer had been appointed in November 2014.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see in staff only areas.

The health and safety policy was supported by risk assessments including: manual handling and access to and from the building. We noted the practice did not have a risk assessment for the control of substances hazardous to health (COSHH) (COSHH regulations are part of the Health and Safety at Work etc. Act (1974. They require all organisations that hold chemicals or other potentially dangerous substances to carry out a risk assessment and retain information relevant to the use and safety of such

substances). A COSHH assessment should have been undertaken to reduce the risk of misuse and make staff aware of what to do if an incident occurred with one of these substances.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff, who had been in post for more than a year, had received training in basic life support. Training in basic life support was booked an undertaken on an annual basis. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible from the practice computer system. The system in use received automatic downloads of new national guidance which helped the GPs and nurses keep up to date with best practice. We noted that the system also contained local protocols from the clinical commissioning group (CCG). We saw minutes of clinical meetings which showed new guidance was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

GPs and nurses described how they carried out assessments which covered all health needs and was in line with these national and local guidelines. We saw that the templates used for assessing patients with long term conditions were current and GPs and nurses explained how care was planned to meet identified needs. There was a system to call patients with long term or complex health needs for regular reviews but this was not being operated consistently. The GPs were aware of the issue and had appointed an additional member of staff to manage recall programmes.

We found the practice had a strong focus on caring for patients with diabetes but was not achieving all the QOF standards. The GPs had access to a specialist in diabetes care via a 'virtual clinic' held every month where the treatment needs of patients finding difficulty managing their diabetes could be discussed and care plans altered or updated with expert advice. Feedback from some of the patients we spoke with who had long term conditions confirmed they were referred to other services or hospital when appropriate.

The GPs held lead responsibilities in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. GPs and nurses we spoke with were open about asking for and providing colleagues with advice and support.

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

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

Management, monitoring and improving outcomes for people

Information about patient's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. The practice had appointed an additional member of staff to oversee and coordinate improvements in systems to both improve existing services to patients and expand the range of enhanced services available. This member of staff held responsibility for managing the recall system for annual health reviews of patients with long term medical conditions. All staff had responsibility for data input and managing child protection alerts and medicines management. The information staff collected was used to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit we reviewed focused on ensuring NICE guidelines were followed when referring male patients aged between 50 and 79 with a raised protein level identified during a test for prostate cancer. The first audit showed that seven out of 17 patients had not been immediately referred and the GPs took action to do so. The audit was repeated a year later when a further 17 patients were identified with raised protein levels and this found all 17 had been referred

Good

Are services effective?

(for example, treatment is effective)

appropriately. Other examples included audits to confirm that the GPs who undertook minor surgical procedures did so in line with their registration and National Institute for Health and Care Excellence guidance.

We saw that 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 the GPs had reviewed their prescribing of antibiotics and found they were low prescribers and following best practice. The prescribing data for these medicines showed the practice to be one of the best performers in the CCG.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice had, for the last two years, achieved a lower percentage of the QOF targets than the national average. They took action to improve their performance by appointing a member of staff in late 2014 to manage the systems for recalling patients and providing data to GPs to ensure they followed up patients with long term medical conditions. It achieved 91% of the total QOF target in 2015. In 2014 it achieved 85%, which was below the national average of 94% for that year. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was worse to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better to the national average
- The dementia diagnosis rate was comparable to the national average

The practice was aware of all the areas where performance was not in line with national or CCG figures and had action plans setting out how these were being addressed.

The team reviewed audit data and approved audits at clinical team meetings. Minutes we reviewed showed us that the team of GPs discussed a proposed audit of patients with kidney disease before the GP who proposed the audit started the audit process. The GPs we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. They spoke positively about the culture in the practice around audit and quality improvement.

The practice's prescribing rates were also better than national figures for prescribing of antibiotics and anti-inflammatory medicines. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question.

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

The practice kept a registers of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with learning disabilities and carers.

GPs 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 audits on their results and use that in their learning.

Effective staffing

Practice staffing included GPs, practice nurses, 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 three number having additional diplomas in obstetrics and gynaecology and one with a diploma 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).

Good

Are services effective?

(for example, treatment is effective)

Most staff undertook annual appraisals that identified learning needs. We saw that all staff had a learning portfolio. However, two of the nine members of staff we spoke with told us they had received two appraisals in the last six years. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a member of the nursing team had taken training in suture removal and another was booked to start a course in managing patients with respiratory disease. 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 GP we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example, in managing patients with 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 hospitals 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 these communications. Out-of hours reports, 111 reports and pathology results were all seen and action taken by a GP on the day they were received. If a GP was absent from the practice another GP was designated to deal with their correspondence. Discharge summaries and letters from outpatients were usually seen and action taken on the day of receipt and all within five days of receipt. 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.

Emergency hospital admission rates for the practice were below the national average at 9.7 per thousand compared to 14.7 per thousand. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for taking action on hospital communications was working well in this respect.

The practice held multidisciplinary team meetings every month to discuss patients with complex needs. 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. The district nurses and health visitors were based in the next door building and had access to the patient record system at the practice which enabled them to update patient records directly and familiarise themselves with action the GPs and practice nurses had taken for patients they worked with. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

When patients were referred to hospital in an emergency there was a policy to either provide a printed copy of a summary record for the patient to take with them to the Emergency Department or for the hospital to access the practice records depending on which hospital the patient attended. The practice had also signed up to the electronic Summary Care Record and this was operational. (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. The software

Good

Are services effective?

(for example, treatment is effective)

enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw that the practice scanned and entered all documents on the patient's record on the day of receipt.

Consent to care and treatment

We found that GPs and practice nurses were aware of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. One of the health care assistants was unsure of the terminology relating to the MCA but we were reassured that they would not treat any patient without consent and that they would seek advice from a GP or practice nurse if they were concerned a patient might not understand the treatment they proposed. GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it. 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, the policy detailed circumstances when an independent advocate may be requested to assist a patient.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All GPs and nurses demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 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 and cervical cytology tests a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

We noted the GPs used 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 also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 159 patients in this age group took up the offer of the health check in 2014. If the results of the health check identified risk factors GPs contacted the patient and called them in for further review, advice and investigations.

The practice had many ways of identifying patients who needed additional support, and it offered additional help. For example, the practice had identified the smoking status of 74% of patients over the age of 16 but this was below the national average. Referral to a local smoking cessation clinic was available. Data available to CQC showed that advice to stop smoking had been given to 65% of smokers identified and that this was below the national average. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. For example, patients identified as obese were offered the opportunity to attend a local service which gave advice on healthy eating and exercise.

The practice's performance for the cervical screening programme was 78%, which did not meet the national target of 80% and was below the national average achievement of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer 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 was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 73% which was similar to the national average. Flu vaccination rates for those at risk were 68% which was above the national average.
- Childhood immunisation rates for the vaccinations given to both under twos and five year olds ranged from 93% to 96%. These were above both CCG and National averages and exceeded the national 90% target.

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 taken between July and September 2014 and January to March 2015. The survey had been sent to 265 patients and 123 of these completed the questionnaire. The practice also sought the views of patients via a virtual representative group of 36 and was taking part in the friends and family test which asked patients if they would recommend the practice to others.

The national patient survey period of January to March 2015 was a time of change at the practice when a GP left and their replacement had not started. Although we noted that the satisfaction ratings had fallen slightly when compared to the practices' 2014 national survey the results were similar or better than both national and Clinical Commissioning Group (CCG) averages. Patients felt they were treated with compassion, dignity and respect. For example:

- 88% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 96% said the nurses gave them enough time compared to the CCG average of 94% and national average of 92%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%

Since January 2015, 86% of the 21 patients who completed the friends and family recommendation test said they would recommend the practice to others.

Five patients completed CQC comment cards and they were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with respect. We did not receive any negative comments. We also spoke with 10 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We saw that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that 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 protocol when discussing patients' treatments so that confidential information was kept private. All staff were required to sign a confidentiality clause linked to their contracts of employment. Staff told us that if they witnessed any circumstances where patient's privacy and dignity was not being respected, they would raise these with the practice manager. The practice switchboard was located away from the reception desk in a separate office which helped keep patient information private. We saw patients waiting at a respectful distance from those checking in at the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. Additionally, 88% said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients gave similar ratings to other practices when responding to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice similar to others in these areas.

For example:

- 81% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 81%.
- 87% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 89% and national average of 85%.

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 were given time to understand the treatment options available to them. Patient feedback on the five comment cards we received was similar to the patients we spoke with.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language but they could not recall any circumstances where this service had been required.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed from was from July to September 2014 and January to March 2015. The practice was, during the second period of the survey, going through a period of GP change with a partner leaving. We noted that the survey results were similar or slightly below local and national averages. For example:

- 82% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were more positive than the survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

GPs told us that if families had suffered a bereavement, their usual GP contacted them and offered support either by a consultation or further telephone contact.at a flexible time and location to meet the family's needs. GPs gave examples of support services they referred bereaved families to and told us about the local talking therapies service which was also available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to patient's needs and had systems in place to maintain the level of service provided. The practice held information about those who needed extra care and resources such as patients with dementia, patients who were carers and other vulnerable patients. This information was utilised in the care and services being offered to patients with long term needs. For example, the practice recognised the needs of carers and information we reviewed showed that the practice had promoted services for this group of patients. As a consequence the number of patients on the register of carers had increased by 33 in 2014. We noted that the practice prioritised appointments for patients who were carers and whenever possible appointments for these patients were brought forward to enable them to return to their caring responsibilities.

There was a named GP responsible for delivering care and treatment to patients living in local care homes and these patients were visited on a weekly rota or when they needed to be seen. All patients in care homes had a care plan and a copy of the plan was kept at the care home.

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

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Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The practice and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties with facilities all on the ground floor. The consulting rooms were accessible for patients with mobility difficulties and there were toilets with wide access doors and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

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

The practice had introduced an online training package in the last year. This included an e-learning module on equality and diversity. Staff training plans included a requirement for this module to be completed every three years.

Access to the service

The practice was open from 8:30am to 6:30pm Monday to Friday. Appointments were available between 8:50am to 12:30pm and 2pm to 6pm on weekdays. The practice usually offered early morning appointments from 7:15am to 8:15am on alternate Tuesday's and opened on Saturday mornings for appointments between 8.30am and 12:30pm. Patients were able to book appointments to see their preferred GP but were able to see any of the GPs if their preferred GP was not available.

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

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 82% were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 75%.
- 88% described their experience of making an appointment as good compared to the CCG average of 78% and national average of 75%.
- 86% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.
- 94% said they could get through easily to the practice by phone compared to the CCG average of 76% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The procedure was available in the patient leaflet, from reception and on the website. Some of the patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the complaints summary for the last 12 months and found all 17 complaints received had been dealt with promptly. All complainants had received a response to their complaints. We tracked three complaints in detail. These showed us that the practice had conducted full investigations, kept the complainants informed at different stages in the investigation and gave a full response, including an apology when necessary.

We noted that the practice had received a number of complaints regarding difficulty in obtaining prescription medicines from the local pharmacy. The practice responded to these by meeting with the pharmacist and introducing electronic transfer of prescriptions which enabled patients to collect their medicines from pharmacies in larger towns nearby.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Requires improvement

(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 mission statement that placed patient safety and welfare at the centre of practice activities. There was a three year business plan covering the years 2014 to 2016. This placed the mission statement at the heart of practice improvement and development. There was evidence that the practice reviewed the content of their business plan. For example, the practice was expanding the range of enhanced services it offered and was planning for the retirement of one of the GPs. We spoke with nine members of staff and they all knew and understood the practice mission statement and knew their responsibilities in relation to it.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a policies folder or on the desktop on any computer within the practice. We looked at five of these policies and found they had been subject to regular review and all were up to date.

There was a leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the partners was the lead for safeguarding. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. The majority told us they felt valued, well supported and knew who to go to in the practice with any concerns. Two members of staff told us they had not received annual appraisals. They had received two appraisals each in the last six years. We also heard that meetings of the administration and reception team, due to be held every quarter, were held infrequently.

The GPs and practice manager had reviewed the staffing structure and appointed additional staff to ensure the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance. In 2013/14 the national average achievement for QOF clinical targets was 94%. The practice had achieved 85% in 2013/14 and 91% in 2014/15. Minutes of meetings confirmed QOF data had been discussed at GP meetings. The GPs and management had set targets for QOF achievement and had not reached the goals they set themselves over the last two years.

The practice also had a programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit of new diagnoses of cancer was carried out and shared with the CCG. These audits identified if the GPs could have made an earlier diagnosis or involved other services at an earlier stage. For example, using the two week wait referral process rather than urgent referral. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were some processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice held a series of staff meetings. We saw minutes of the GP meetings which showed governance and performance issues were discussed. Some members of the administration and reception team we spoke with told us that meetings for this group of staff were held but they were infrequent. For example, a meeting planned for March 2015 had been cancelled because the member of staff who organised the meeting was absent. The minutes we were able to review from meetings of administrative and reception staff focused on day to day performance and practical matters.

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 which were in place to support staff. There was a staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

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

Are services well-led?

Requires improvement

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

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

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

We found the practice had made significant effort to establish a Patient Participation Group (PPG) (A PPG is a group of patients registered with a practice who agree to work with the practice to improve services and the quality of care. PPG's would hold formal meetings with the practice). An open evening had taken place in May 2015 and a follow up was planned for July. Despite these, and earlier, efforts an active PPG was not in place. There was a virtual Patient Representative Group (PRG) of 36 patients who maintained contact with the practice by e-mail and commented upon the way the practice offered and delivered services when requested to do so. We saw a report the practice had prepared on patient feedback. This detailed action taken, for example increasing the numbers of appointments available on a Tuesday morning and Saturday morning in response to patient comments. We also found the practice had purchased two new chairs with higher seats and arms to assist patients who found it difficult to get up and down from low chairs.

The practice was engaged with Newbury and District Clinical Commissioning Group (CCG) and had recently signed up to offer a wider range of services. We found the practice open to sharing and learning and engaged openly in multi-disciplinary team meetings. One of the GPs and the practice manager attended CCG meetings and reported back to the practice on CCG priorities.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and there was evidence they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, one member of the nursing team had taken training in removing stitches because the nursing team had identified more appointments were required for patients needing this service.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at records which showed that most staff received regular appraisals. However, the appraisal system was not operated consistently. There were two members of administration staff who had not received regular appraisals. Staff told us that the practice was very supportive of training. All staff had access to e-learning and GPs and practice nurses attended training events organised by the CCG. However, we found that not all staff designated to undertake chaperone duties had been trained in this role. We also found that health care assistants were unclear on how to apply the Mental Capacity Act (2005) and had not received training in this piece of legislation. The practice must address essential training needs to further improve patient safety.

The practice was a GP training practice approved for one GP in training. We spoke with the GP in training and they told us they were well supported at the practice. We noted they had longer appointment times and that an experienced GP was always on duty to support them.

The practice had completed reviews of significant events and other incidents. These were shared with staff via their line manager or the practice manager.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 Staffing** 2) Persons employed by the service provider in the provision of a regulated activity must – (a) receive such appropriate support, training, professional development and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Appraisal systems were operated inconsistently. Not all staff were receiving regular appraisal. Staff awareness of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) was inconsistent and could place patients lacking capacity to consent to care and treatment at risk. Staff had not been appropriately trained to carry out chaperone duties.