Mortimer 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

We undertook a comprehensive inspection of Mortimer Surgery on the 12 November 2014. Overall we have rated the practice as good. The practice was rated requires improvement in safe and good in the other four domains.

Our key findings were as follows:

Generally the feedback from patients was very positive. Patients we spoke with said they were very happy with the service they received. Patients were complimentary of the practice staff. Most patients were happy with the appointment system and all knew they could speak to a doctor or a nurse over the phone whenever they needed to.

We found medicine management systems did not always follow national guidance. We found some of the recruitment information required by within regulation was not recorded in the individual staff files.

The results from the national GP survey showed, 88% of patients said the last appointment they booked was convenient. Eighty eight per cent of patients said the last GP the spoke with was good at giving them enough time and 80% of patients were able to get an appointment to see a GP or nurse the last time they tried.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

We found the service was responsive to patient's needs. 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 is well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

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

Summary of findings

Importantly, the provider must:

- Ensure all recruitment and employment information required by the regulations are documented in all staff members' personnel files.
- Ensure medicine management and dispensing systems are reviewed and reflect national guidelines.

In addition the provider should:

- Ensure all the dispensing team receive regular support with professional development and appropriate training.

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 medicine management systems did not always follow national guidance. We found some of the recruitment information required by within regulation was not recorded in the individual staff files. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. 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. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. Patient'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 had been identified and planned. The practice had undertaken appraisals and developed personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and 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. Urgent appointments were available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information

Summary of findings

about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning took place from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The patient participation group (PPG) was active. Staff had received inductions 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 provided good quality care to older patients. All patients over 75 had a named GP. Home visits were offered to elderly and frail patients. Patients at risk of an unplanned hospital admission had a care plan in place. Data showed the practice had good clinical outcomes for older patients. District nurses and palliative care nurses were involved in surgery meetings to ensure that care for patients at the end of their lives was co-ordinated. Older patients had access to comprehensive range of carer's information at the practice, with many links to various supportive organisations. These included information on local befriending services and dementia support groups. The practice offered various screening programmes for older patients, such as bowl and dementia screening. The practice had exceeded the national bowl screening target and 513 patients had received dementia screening in the last six months.

People with long term conditions

Good

The practice was rated as good for the care of patients with long term conditions. Patients at risk of being admitted to hospital due to their condition had a care plan in place, and this was regularly reviewed by a GP. When needed, longer appointments were available and this was supported by some of the patients we spoke with. A large amount of health advice and medical condition information was available on the practice website with many links to various supportive organisations. Leaflets were also available at the surgery. A recall system was in place to ensure patients with long term conditions received appropriate monitoring and support. The practice held regular clinics for long terms conditions such as asthma, diabetes and hypertension and coronary heart disease. The practice ran regular cardiovascular disease health check clinics. These clinics involved looking at specific risk factors for heart disease and strokes. Through these clinics patients were provided with advice on healthy eating and importance of regular exercise. Any issues identified were then referred to a GP and risk assessments were put in place accordingly.

Families, children and young people

Good

The practice was rated good for the care of families, children and young patients. Staff knew their patient population very well and the practice had systems in place to identify children or parents at risk. The practice held regular safeguarding meetings, where child protection issues were discussed and learning was shared. Children

Summary of findings

and young patients were treated in an age appropriate way and their consent to treatment using appropriate methods was requested. The practice ran regular clinics to support this population group, which included contraceptive and antenatal clinics. Patients were able to make an appointment with a GP or a health visitor for advice and counselling on pregnancy. The practice achieved 98% on their child immunisation compared to a national average of 95%. The provided medical services to a local school and dedicated weekly appointments were available for these students. The practice worked closely with health visitors, midwives and school nurses. Appointments were available outside of school hours and the practice facilities were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice was rated as good for the care of working age patients. Emergency appointments, telephone consultations, a later clinic on a Monday and an extra evening and Saturday clinics were available to accommodate patients working between the hours of 9am and 5pm. Self-management programmes for conditions such as thyroid were provided to patients and they were supported by a GP or nurse for these programmes. The practice had introduced an online appointment booking system, which allowed patients to easily view, book and cancel appointments via internet. In addition, telephone appointments were offered for advice on medication, prescription and test results

People whose circumstances may make them vulnerable

Good

The practice was rated as outstanding for the care of patients living in vulnerable circumstances. There were no barriers for patients in vulnerable circumstances. Patients wishing to register at the practice were always accepted. The practice maintained a learning disability register and these patients received an annual review. Staff understood about safeguarding vulnerable patients, they had access to the practice policy and procedures and they were appropriately trained. The practice held regular palliative care and safeguarding meetings, where vulnerable patients were discussed.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the population group of patients experiencing poor mental health (including patients with dementia). Patients with mental health problems received annual reviews. GPs attended Care Programme Approach (CPA) meetings, to discuss patient specific treatment and care plans. The CPA is the framework

Summary of findings

for providing care to patients with mental health problems and patients with learning disabilities who also have mental health problems. The practice sign-posted patients experiencing poor mental health to various support groups.	

Summary of findings

What people who use the service say

We spoke with nine patients which also included members of the patient participation group (PPG). A PPG is made up of a group of volunteer patients and practice staff who meet regularly to discuss the services on offer and how improvements can be made for the benefits. We received further feedback from 32 patients via comment cards. Majority of the feedback from patients was very positive. The patients we spoke with said they were very happy with the service they received.

Patients were complimentary of the practice staff. Reception staff in particular were praised for their helpfulness and the nurses and GPs were praised for their compassion and effective treatment.

Most patients were happy with the appointment system and all knew they could speak to a doctor or a nurse over the phone whenever they needed to. Patients told us they were able to request to see a GP of their choice and they felt their requests were met whenever possible. All patients spoken with were happy with the cleanliness of the environment and the facilities available.

Patients said GPs and nurses explained procedures in great detail; they had opportunities to ask questions and felt involved in the decisions about their care and treatment. They said they were given printed information when this was appropriate. Patients told us they had been offered a chaperone during consultations if this was appropriate, and they said there were notices in consultation rooms telling them that chaperones were available. Chaperone information was also available on the practice website.

We reviewed patient feedback from the national GP survey from 2014 which had approximately 128 responses. The results from the national GP survey showed, 88% of patients said the last appointment they got was convenient. Eighty eight per cent of patients said the last GP the spoke with was good at giving them enough time and 80% of patients were able to get an appointment to see a GP or nurse the last time they tried. Overall 81% of patients said they would recommend the practice to someone new to the area.

Areas for improvement

Action the service MUST take to improve

- Ensure all recruitment and employment information required by the regulations are documented in all staff members' personnel files.
- Ensure medicine management and dispensing systems are reviewed and reflect national guidelines.

Action the service SHOULD take to improve

- Ensure all the dispensing team receive regular support with professional development and appropriate training.

Outstanding practice

- Patients had their needs assessed and care planned in accordance with best practice. The practice had an exemplar diabetes care planning system in place.

Mortimer Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, and a GP specialist advisor. The team included a Pharmacist specialist advisor and a practice manager.

Background to Mortimer Surgery

The practice provides medical services to over 11700 registered patients in Mortimer, Berkshire and is a dispensing practice. The practice serves an older than average practice population and with low deprivation scores. Mortimer Surgery has a high number of patients registered who are over 65 year old. Local demographic data indicates the practice serves a population which is one of the more affluent areas in England.

The practice has been extensively extended and modernised to meet patient needs, in the recent years. Further development plans have been discussed and plans have been made for this work to be completed in the next year. This includes developing a treatment room and building another consultant room. The practice building is also occupied by other NHS and private health providers.

All consulting and treatment rooms are located on the ground floor. Care and treatment is delivered by a number of GPs, practice nurses, dispensary team, health care assistants and phlebotomist. In addition, the practice is supported by midwives who are based on the premises. The practice also works closely with district nurses. Mortimer Surgery also provides other medical services in-house, such as physiotherapy, counselling and chiropody.

The practice is involved with the local and clinical commissioning group (CCG); one of the GP partner has an active role in the CCG. The practice has a Primary Medical Services (PMS) contract.

The practice is a GP training practice, which looks after GP registrars as well as medical students in years four and five of the Oxford and Wessex Deanery. This was a comprehensive inspection.

There were no previous performance issues or concerns about this practice prior to our inspection.

The CQC intelligent monitoring places the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice provides services from:

Mortimer Surgery

72 Victoria Road

Mortimer Common

Reading, Berkshire

RG7 3SQ

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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 reviewed wide range of intelligence we hold about the practice. Organisations such as local Healthwatch, NHS England and the clinical commissioning group (CCG) provided us with any information they had. We carried out an announced visit on 12 November 2014. During our visit we spoke with practice staff team, which included GPs, practice nurses, the dispensary team, a health care assistant (HCA), and the administration team. We spoke with nine patients including the Patient Participation Group (PPG) members who used the service and reviewed 32 completed patient comment cards. We observed interactions between patients and staff in the waiting and reception area and in the office where staff received incoming calls. We reviewed policies and procedures the practice had in place.

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

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.

We reviewed safety record and incident reports. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term. We saw evidence to show drug recalls were actioned appropriately and this information was documented for future reference.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed significant events that occurred during 2014. The practice discussed significant events during clinical team meetings, which were attended by the GPs and nursing staff. There was evidence appropriate learning had taken place where necessary and that the findings were shared with relevant staff. Staff we spoke with told us they were able to raise issues during team meeting and were encouraged by the practice manager to do this.

Reliable safety systems and processes including safeguarding

The practice had safeguarding policies and procedures to protect vulnerable patients. A safeguarding lead had been appointed and undertaken appropriate safeguarding training. The safeguarding lead attended safeguarding case conferences regularly and any changes or learning were communicated to the team through team meetings. All staff members received regular training to enable them to protect children and vulnerable adults from abuse. A training log containing records of this was made available to us. The GPs and nursing staff we spoke with knew of their responsibilities regarding information sharing and documentation of safeguarding concerns. The reception and administration staff were able to tell us what they would do if they suspected abuse and were familiar with the practice safeguarding policies. Staff told us that they would raise a safeguarding concern either with the lead GP or with the practice manager. Patients we spoke with told us they felt safe when attending the practice.

The practice had chaperone policy and this service was advertised in the reception area and in consulting rooms. A chaperone is an individual who is present as a third person during intimate examination by a healthcare professional of a patient of the opposite sex. All practice staff were able to perform chaperone duties. We saw evidence all practice staff had been subject to a criminal records check through the Disclosure and Barring Service and these were recorded in their personnel files. Although the staff had not received formal chaperone training, all staff had been given guidance and information on the role by one of the partner GPs. The staff we spoke with, who had performed chaperone duties, had a sound understanding of the role and their responsibilities.

Staff we spoke with told us they would not hesitate to report poor practice or concerns. Whistleblowing is when a worker reports suspected wrongdoing at work, if they had any reason to. This could be for example, if anyone at work was neglecting their duties.

Medicines management

We saw there were medicines management policies in place, and the staff we spoke with were familiar with these. We saw detailed standard operating procedures (SOP) for using certain medicines and equipment. We checked the medicines held at the practice. These were all appropriately stored and were within their expiry date. Medicines to be used in the case of an emergency were available. We saw that these were checked by the practice nurse to ensure they were available and within their expiry date.

All prescriptions were signed by the GP before they issued to the patient. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. The practice operated a 'buddy system' for GPs to sign prescriptions if the original GP was not available.

There was a system in place for reviewing repeat prescriptions and we were told that patients who failed to attend for their prescription review were followed up and reminded to attend their review. We saw evidence acute prescriptions signed at the time of the consultation.

Requires improvement

Are services safe?

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.

Practice staff undertook regular checks of controlled drug prescribing to look for quantities and dose. An independent check of controlled drug balances was carried out every six months. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area

However, we found controlled drug requisition orders were not being signed by the GP. There is a legal requirement these are signed by a GP. This was also reflected in the practice's own SOP ordering controlled drugs protocols.

The practice did not have adequate security system for prescriptions. The prescriptions were put into nine printers across the surgery. There was no way of tracking the numbers, which meant if prescriptions were stolen, the practice would not know how many were missing. In addition, we found printed prescriptions were left unsecured on GPs desk overnight, for them to be signed. All of the consultation rooms did not have locking facilities.

We found the practice did not have appropriate stock systems in place. There was no stock list or stock control. Staff did not know how much stock was held, this was all checked manually. Staff told us stock take took place only once a year. This meant if medication was missing the practice would not be able to track this.

We found the practice kept adrenaline in the emergency boxes which GPs took with them on home visits; however these were for self-administration and not for health care professional administration.

The practice was not carrying out any second checks for majority of the dispensing. The practice was also not completing second checks for pre-packed medication dispensing, and had approximately 40 patients receiving pre-packed medication dispensing. There were no systems in place to monitor or review this practise.

The practice had inadequate systems for checking dispensary and vaccine fridge temperatures. We found there was no minimum or maximum temperature recorded for the dispensary fridge. The practice did not use second independent thermometer, independent of the power source, to monitor temperature. We found there was no label on the vaccine fridge in one of the treatment rooms, to alert staff the fridge should not be unplugged. The dispensing team did not have access to an up to date copy of the British National Formulary (BNF).

Cleanliness and infection control

During our inspection we looked at all areas of the practice, including the GP surgeries, nurses' treatment rooms, patients' toilets and waiting areas. All appeared visibly clean and were uncluttered. The patients we spoke with commented that the practice was clean and appeared hygienic.

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.

The practice had a lead for infection control. Staff had received training about infection control specific to their role and had received annual updates. We saw evidence that audits of infection control processes and the practice environment had been undertaken in the last year.

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.

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.

Equipment

Staff had access to oxygen and the equipment was checked and recorded regularly to ensure it was in working order. All

portable electrical equipment was routinely tested. A schedule of testing was in place. We saw a log of calibration testing for the practice and all equipment had been tested this year.

Staff we spoke with knew the location of the resuscitation equipment. We saw evidence all staff had received training in resuscitation and refresher training had been planned. Some staff had had completed training in health and safety and fire safety. Health and safety and fire evacuation procedures were available in the staff handbook.

Staffing and recruitment

Recruitment policies and procedures were in place. We reviewed the personnel files of five staff members, of staff that had been recruited in the last two years. We found some of the information required by the regulation was recorded in the individual staff files. This included employment contracts, application forms or Curriculum Vitae (CVs), any employment gaps had been explored and reasons recorded on file and criminal records checks through the Disclosure and Barring Service (DBS).

We found there was no evidence of references being sought for three staff members. For the other two staff members we were told verbal references had been sought, however there was no written evidence in staff files to support this. The practice had not obtained evidence for staff to ensure they were physically and mentally fit to carry out their roles. One file did not include a recent photograph of the staff member. Two staff files did not include evidence of completed identity checks.

There was a rota system for 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.

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.

We found the staffing levels in the dispensary team were low. For example, we found there were seven sessions (out of 10 sessions) where only one member of staff was working in the dispensary. Dispensary team told us this often led to stressful environment for staff. This meant the current system presented high risk for mistakes being made, as the practice was not carrying out second checks on their dispensing.

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 had a comprehensive fire risk management and health and safety policies and procedures in place and risk assessments were carried out. The business continuity plan identified the range of risks the practice could face that would prevent the delivery of care and treatment. The plan identified how these risks would be mitigated and actions needed to restore services to patients.

Arrangements to deal with emergencies and major incidents.

The practice had arrangements in place to manage emergencies. 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.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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 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 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 interviewed were aware of their professional responsibilities to maintain their knowledge.

Patients had their needs assessed and care planned in accordance with best practice. The CQC specialist GP advisor sampled five patient records for patients who were assessed for diabetes. We found patients had received a comprehensive assessment and results were shared with the patient, before their consultation with the nurse. This ensured that all relevant information was available and a new development plan for the patient could be put in place. We saw evidence robust written care plans were devised. Advice on management and control of their condition was provided and a personalised written care plan was given to the patient to take with them on their visits to the diabetic specialist nurse. This encouraged the patient to take ownership and overall responsibility for their wellbeing.

We saw that patients were appropriately referred to secondary and community care services. Referrals were discussed during clinical meetings. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

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

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. The practice used the Quality and Outcomes Framework (**QOF**) which is a voluntary system for the performance management and payment of GPs in the National Health Service. This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The practice achieved 98% on their QOF 2013 score compared to a national average of 96%. Data from the QOF showed how the practice had performed well on specific disease areas including palliative care, diabetes and chronic obstructive pulmonary disease (COPD).

The practice had a system in place for completing clinical audit cycles. These included audits for urinary tract infections, repeat prescribing, and chronic obstructive pulmonary disease admission audits. For example, we reviewed prescribing audit dated October 2014. This audit had identified several recommendations. These included, the requirement of all prescriptions for dispensary patients were to be signed before medication was handed out to the patient and any additions, amendments or deletions of medicines on a patient record following a hospital discharge would need to be authorised and checked by a clinician. We saw evidence key points had been summarised, learning was shared with staff, and practice policies were updated accordingly. We noted a re-audit was planned in six months' time. Other examples included audits of home visits, emergency admissions and medication.

Effective staffing

Practice staffing included medical, nursing, 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 diverse specialist interest such as, dermatology, migraine, family planning, sports, rheumatology and paediatrics.

Good

Are services effective?

(for example, treatment is effective)

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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

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 running cardiovascular clinics. 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.

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.

All the patients we spoke with were complimentary about the staff. We observed staff who appeared competent, comfortable and knowledgeable about the role they undertook.

We found members of staff involved in the dispensing process were appropriately qualified. However, their competence was not checked regularly. There was no formal support with continuing professional development or regular training for the dispensing team.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services who shared the building and professionals from other disciplines to ensure all round care for patients. Minutes of meetings evidenced that district and palliative nurses attended the GP quality team meeting to discuss the palliative patients registered with the practice. The detail evidenced good information sharing and integrated care for those patients at the end of their lives.

The practice worked with other service providers to meet patient's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, the practice used electronic systems for making referrals. 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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to accident and emergency. The practice has also signed up to the electronic Summary Care Record and this was this fully operational from December 2014. (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 called VISION to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a consent policy. The GPs and nursing staff had access to guidance and information for the Mental Capacity Act 2005. The clinical staff we spoke with understood the key parts of the legislation and described how they implemented it. Staff were able to describe the action they would take if they thought a patient did not understand any aspect of their consultation or diagnosis. This ensured patients who were either unable or found it difficult to make an informed decision about their care could be supported appropriately. They were aware of how to access advocacy services. GPs and nurses obtained written consent was sought for all photography/video recording during consultations.

Good

Are services effective?

(for example, treatment is effective)

The GPs and nurses had a sound knowledge of the Gillick competency considerations, when dealing with younger patients. Gillick competence is used to decide whether a person (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental consent or knowledge.

Health promotion and prevention

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register for all patients with learning disability and these patients were offered annual health checks. The practice also kept diabetes and carer's register and monitored these patients to ensure they received regular medical reviews.

The practice had adopted a thyroid self management system for appropriate patients on thyroid medication. GPs used this system to ensure all these patients received regular checks and help facilitate patient compliance. The practice nurse told us diabetes, asthma and chronic obstructive pulmonary disease (COPD) had personalised care plans and were provided with appropriate supporting information. The practice ran a 'Pre Diabetes' service for patients, to provide advice and information on how to improve health and adopt healthy lifestyles.

The practice aimed to reduce inappropriate emergency hospital admissions. Personal care plans were put in place for the patients most at risk of hospital admission. These were regularly reviewed during monthly meetings and good progress was being made. The practice was also looking at preventing A& E admissions, by carrying regular audits.

A range of literature was accessible in the practice waiting room and on the practice website to support patients with health promotion and self-care. Health promotion and prevention was promoted through consultations. GPs and nurses signposted young patients to local sexual health services for further support and advice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

On the day of the visit we observed that staff interaction with patients was respectful and friendly.

Patients spoke highly of the practice, the reception staff and the GPs. Patients described staff as caring, kind and respectful. The rooms were suitably equipped and laid out to protect patient privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and conversations could not be heard through closed doors. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and practice surveys. The evidence from most of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national GP survey 2014 showed 74% of patients said the last GP they saw was good at treating them with care and concern and 84% of patients found the receptionists at the practice helpful. Sixty seven per cent of patients said they were satisfied with the level of privacy when speaking to receptionists at the practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 32 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a very good service and that staff were efficient, understanding and caring.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed the practice scored below national average in questions about patient's involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey 2014 showed 69% of patients said the last GP they spoke with was good at involving them in decisions about their care and 77% of patients said the last GP they saw or spoke to was good at explaining tests and treatments. However, the nursing team scored well. For example, 78% of patients said nurses were good at giving them enough time and 78% of patient stated nurses were good at listening to them. Both these results were below average compared to CCG and national results.

The nine patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and they supported these views.

Data showed us care plans were in place for patients receiving end of life care. 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. The practice website carried a facility to translate information into 80 different languages.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with told us staff offered compassionate support to patients when needed. They told us they had received help to access support services to help them manage their treatment and care when it had been needed. Several patients said practice staff would went above and beyond what was required to make sure the care offered was appropriate. The responses we received from comment cards were also consistent with this feedback.

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

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and 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. One of the GPs was a member of the CCG board and brought issues back to the practice for discussion with colleagues.

A range of clinics and services were offered to patients, which included family planning, antenatal menopause, smoking cessation, and sexual health. The practice ran regular nurse specialist clinics for long-term conditions. These included diabetes, asthma 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.

The practice had systems in place with secondary care providers to ensure information was available when a referral was made or when results where available. Any action requested by the hospital or Out of Hours (OOH) service was communicated to the practice.

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. The PPG had also devised a contact list for all support organisations in Berkshire and nationally, that patients could approach for further advice and support. This included support organisations for bereavement and alcohol and drug abuse.

Tackling inequity and promoting equality

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

The practice had access to a telephone translation service when a patient did not speak English as a first language. 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. Staff told us written information could be made available in large print for patients with a visual impairment. The patient calling system in the waiting room was both audio and visual.

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.

Some staff had received equality and diversity training in the last 12 months.

Access to the service

Appointments were available from 8:30am to 6pm on Mondays-Thursdays and from 8.30 to 5pm on Friday. Later evening clinics were held on some Tuesday's and Thursday's with appointments scheduled until 8pm. The practice did not close during lunch time and urgent treatment could be accessed during this time.

There was a good appointment system where patients could receive same day emergency appointments, pre-bookable appointments, telephone consultations with their named GP whenever possible, call backs, and home visits by the doctors. Patients were able to book appointments in person, by telephone or online. Caseloads were discussed and altered in order to maintain consistency for patients at local schools. Reception staff told us the appointment system worked very well, and this was supported by most of the patients we spoke with.

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

Longer appointments were also available for people who needed them and those with long-term conditions. This

Good

Are services responsive to people's needs?

(for example, to feedback?)

also included appointments with a named GP or nurse. Home visits were made to a local nursing care home on a specific day each week, by a named GP and to those patients who needed one.

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.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. A poster setting out how to make a complaint was displayed on a notice board. Information on how to make a complaint was also provided on the practice website and leaflet. The complaints procedure provided further information on how the complaint will be dealt with by the practice and the time limit within the complainant will receive a written response. Patients were also provided details of external organisations they could refer there complaint, if they were not happy with the response provided by the practice. 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.

The practice kept a record of all written complaints received. The complaints we reviewed had been investigated by the practice manager and responded to, where possible, to the patient's satisfaction. The practice was open about anything they could have done better, and there was a system in place so learning as a result of complaints was disseminated to staff.

We found patients' comments made on the NHS Choices website had been monitored. We noted the comments were mixed with some patients complimenting the service and the practice staff and other comments were less positive. We saw all negative comments had been responded by the practice.

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.

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 had a clear vision to deliver high quality care and promote good outcomes for patients. It actively promoted a learning culture. There was a real emphasis on research, teaching and training, to ensure there was continuous improvement and effective delivery of service.

We found details of the vision and values were part of the practice's strategy and five year business plan. The commons themes in the strategic plan included, to offer caring and compassionate care to all and to provide training and teaching to all staff to ensure clinical excellence is achieved. In addition the practice was keen to adopt and had explored advance IT solutions, such as consultations via internet telephone and video conferencing. This would increase patient choice and improve accessibility.

The GP partners and the practice manager attended neighbourhood and Clinical Commissioning Group (CCG) meetings to identify needs within the community and tailored their services accordingly. For example, the practice had recently discussed with the local CCG about employing a consultant geriatrician onsite. They were also reviewing the possibility of recruiting specialists in areas such as rheumatology and dermatology onsite.

The practice charter was displayed and was available on the practice website. Values included in the charter included the targets of seeing patients on time, informing patients of local supportive organisations and to ensure medical services are accessible to all in a timely manner.

All the staff we spoke with were aware of the vision and values of the practice and knew what their responsibilities were in relation to these. We saw that the regular staff meetings helped to ensure the vision was being upheld within the practice.

Governance arrangements

We saw systems in place for monitoring aspects of the service such as complaints, incidents, risk management and clinical audits. The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. All the policies we looked at had been reviewed and were up to date. The systems and feedback from staff showed us that strong governance structures were in place.

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 repeat prescribing and chronic obstructive pulmonary disease (COPD) prevalence 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

There was a clear leadership structure with named members of staff in lead roles. Staff had both clinical and functional lead roles. For example, there was a lead nurse for infection control and a partner was the lead for safeguarding. Other lead roles included, an IT lead, teaching lead and prescribing lead. All the staff we spoke with were 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.

Staff told us kept informed of important issues via their line managers and through systems of team briefings and team meetings. We saw from minutes that team meetings were held regularly. We saw topics such as complaints, significant events and training needs were discussed. Staff said there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held annually.

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 2013/2014 patient satisfaction survey. The survey had identified patients were experiencing difficulties accessing the practice via the

Are services well-led?

Good

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

telephone system. The practice responded by purchasing a new upgraded telephone system. The PPG members told us patients will be asked in next year's questionnaire, if the new telephone system had improved accessibility.

The practice had an active patient participation group (PPG). The PPG had carried out annual surveys and met bi-monthly. Meetings were held in the evening to enable patients of working age to attend. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were published on the practice noticeboard and website.

PPG members we spoke with told us they felt the practice listened to the views of patients and acted upon them. We were given examples of where the PPG had highlighted areas where improvements could be made, for example improvements to the telephone system and the online booking system. They told us the management team listened to their concerns, made improvements, and monitored these to ensure patients were happy.

Patients spoken with reported that they felt comfortable providing concerns, compliments or complaints to all members of staff. All the staff we spoke with said they felt they were valued and their views about how to develop the service were acted upon. Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns.

Management lead through learning and improvement

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. Clinical team meetings were used to disseminate learning from significant events and clinical audits. Staff told us changes to protocols and policies were made as a result of learning outcomes from significant events, national guidance and audits.

We saw a clear understanding of the need to ensure that staff had access to learning and improvement opportunities. Newly employed staff had a period of induction. Learning objectives for existing staff were discussed during appraisal. We saw evidence staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. We saw evidence appraisals for next year had been planned for all staff. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise.

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 **The registered person must protect patients against the risks of associated with unsafe use and management of medicines, by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person must ensure all information specified in Schedule 3 is available in respect of staff employed for the purpose of carrying on the regulated activity. Regulation 21 (a) & (b).**